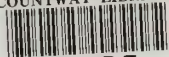
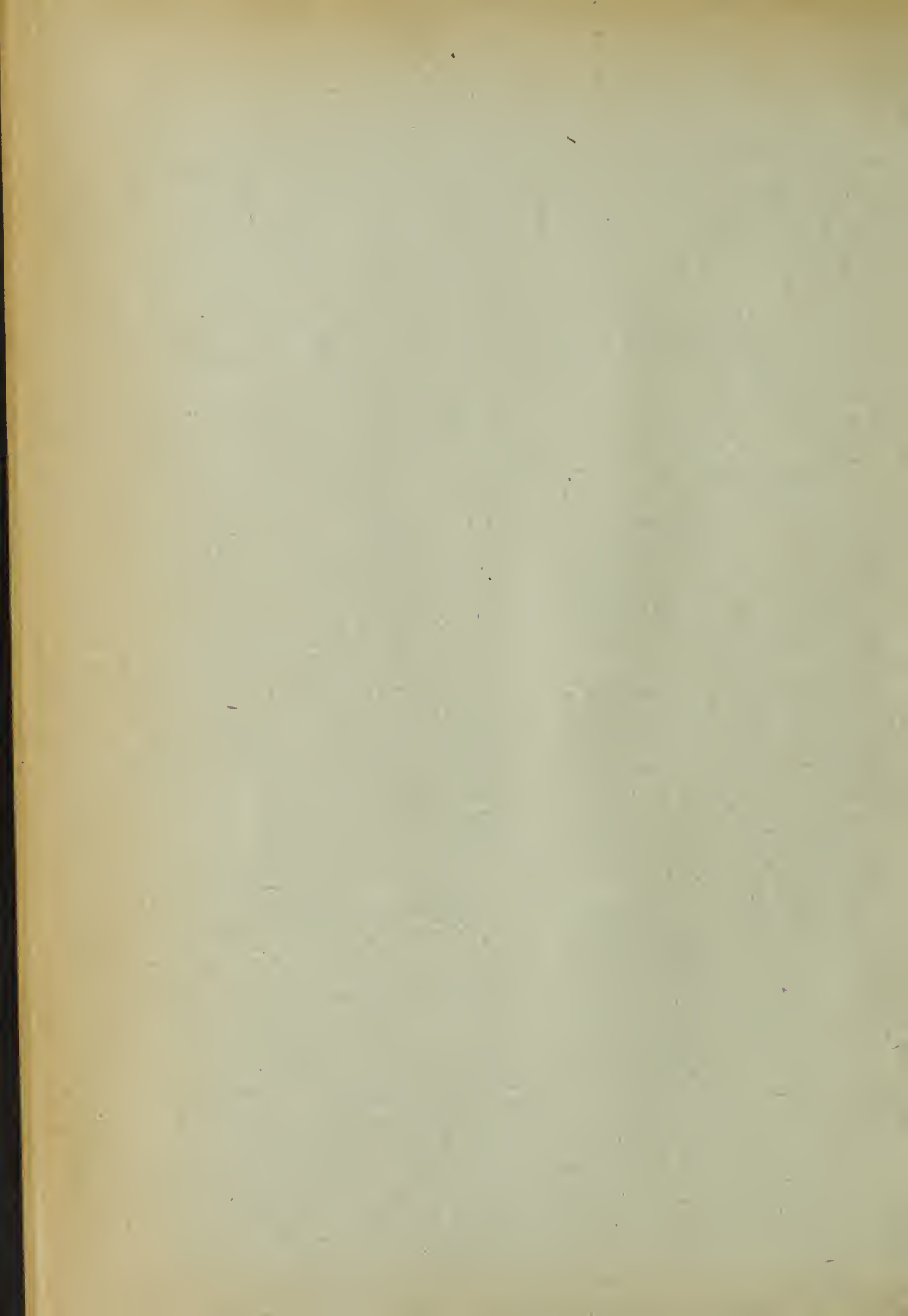


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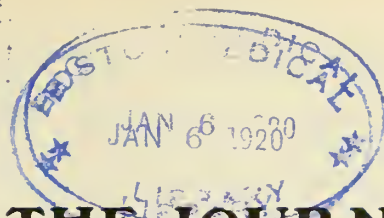
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No. 1

Is the War or Weather Responsible for the Recent Prevalence of Pregnancy Toxemias?

A Study of Results of Standardized Treatment of Forty-Four Cases.

By GEORGE CLARK MOSHER, A.M., M.D.,
F.A.C.S., Kansas City, Mo.

During the present winter, the writer has had under observation either among his own patients or among those referred or seen in consultation twenty-two cases of pre-eclamptic toxæmia or eclampsia. During the year thirty-nine cases have been managed. Within the last twelve months have also been met five cases of pernicious vomiting which is, of course, another type of toxæmia of pregnancy.

On a brief trip to the hospitals of Chicago in conjunction with Dr. Buford G. Hamilton, my junior on the staff at the Kansas City General Hospital, we found on taking up the subject at the Chicago Lying-In, Presbyterian, Wesley, Augustana, St. Luke's and Cook County Hospitals, that in each of these, maternity services had been observed an unusual percentage of pathological cases during the winter.

Now, why there should be in the six weeks from January 1st to February 15, 1918 as many such cases as would ordinarily be met in a year is a mystery. We are at a loss to account for the frequency of toxæmia except by charging it either to the extreme changes in temperature from a bitter cold to mild weather and back again just as epidemic jaundice and herpes zoster has in some seasons been ascribed to climatic conditions or else

to the nervous unrest and tension from which every sensitive woman suffers on account of our entrance into the War. Nearly every family has some of its younger men in the service and even those who do not, are strung up through such abnormal conditions so that the resistance is far easier overcome and if the patient has a tendency to be under par, she loses her equilibrium of absorptions and eliminations.

The insufficient elimination of toxins generated at the placenta site and by the foetus, together with the extra burden thrown on the organism of the mother to provide for oxygenation for herself and the developing child, become greatly increased because of the loss of equilibrium between the surface of the body and the heat centers, owing to extreme cold weather. This may interfere with the metabolism to such a degree as to produce an acidosis, as is claimed by Martin Fischer in his argument showing the relation of oedema and acidosis. Hence the logical advantage of magnesium sulphate in eclampsia, it being the salt best qualified to overcome oedema. Nervous strain produces fatigue, insomnia and faulty metabolism.

Eclampsia which still claims a death rate of 25 to 40 per cent by the average of statistics, was a long time ago designed by Wweifel as the disease of theories. We have not been able to reach a basis up to the present day where we could absolutely prove its origin or trace its etiology. The signs and symptoms are, of course, familiar, and the findings at autopsy, liver, kidney and brain necrosis, all have been seen. From these facts, we gain the clue

upon which our plan of treatment is founded, but while experimental evidence and grouped phenomena are helpful, every man draws his own conclusions from the cases he has seen and applies them according to his own mode of reasoning, which may be a temporary theory or it may become an obsession.

As witness of the statement that toxæmia is yet not without the bounds of theory, one's attention is called to a most valuable article on "Treatment of Eclampsia" by Dr. J. Clifton Edgar in the *Journal American Medical Association* of last week, April 27, 1918. Dr. Edgar says, "A one time advocate of active medical and surgical treatment and bitterly opposed to morphine in eclampsia experiences in the last five years has radically changed my views and teaching." "I am still uncertain whether morphin increases infant mortality." "A one time enthusiast in the free use of veratrum viride in eclampsia, I frankly confess to having changed my views. I fear its shock producing effect, although I still occasionally employ it in small doses in selected cases." In other respects Edgar's treatment varies but little from our own established technique.

In a paper by D. M. Erwin of the Department of Pathology, University of Cincinnati are the results of some striking research work in regard to the relation of blood pressure to convulsions—*Jour. A.M.A.*, April 27, 1918. His contention is that: "The chemical substance in the blood only produces oedema. The height of the blood pressure over the intra cranial is the margin of safety. When this margin is at a small positive quantity, the brain must undergo some change. The vaso motor center fags. As a consequence the blood pressure which has been maintained as high as possible drops. The intra-cranial pressure now becomes greater than the blood pressure; the margin is negative; the pupils dilate and convulsion comes on; the sharp tense contraction of the muscles play a vicarious part, by forcing the blood from the periphery, and raising that in the brain until the margin is again posi-

tive. With its renewed blood supply the centers again take up, for the time, their work."

Knowing that next to sepsis, eclampsia is the most deadly of all obstetric complications, every woman has been, on coming under observation examined with the realization that her symptoms may possibly suggest at any time that she is a pre-eclamptic. As early as her pregnancy is recognized, blood pressure, eye symptoms and urinalysis are made a routine: the teeth and tonsils inspected for foci of possible infection.

The etiology of eclampsia as formulated into a table of relative values is as follows:

1. Failure of elimination of toxins; these in the early months are doubtless due to the placenta, and in the second half of pregnancy doubtless to the excretions of the foetus.

2. Infections of various types throw a burden on the pregnant woman.

3. Resulting from pressure and from stasis with a decrease of normal power of maternal oxygenation, thus interfering with lung expansion, and with the action of the heart, we have an asphyxia of greater or less degree.

LaVake has pictured a woman pregnant who has thus thrown on the excretory organs a double load.

The patient who has had a previous scarlet fever or some similar disease, is handicapped in elimination of bacteria or their toxins which emanate from such foci as infected tonsils or teeth, or from colon bacillus. These may further damage her resistance.

The basic feature of etiology is from the placenta or the foetus. The degree of overwhelming by the toxins is dependable on the two conditions—first; rapidity of the generation of the toxins; and second, the compensatory ability shown by the organs of elimination to throw off the poison.

Beyond question there are depressing effects from the presence of the toxin shown by the lesions in kidney, liver and

heart. These add to the risk of the pregnant woman.

The foetus makes still heavier demands on the powers of oxygenation on the part of the mother in the later months of pregnancy, and having been reduced by the stasis of the abdominal organs, resulting from pressure through the diaphragm, this demand is followed by decreased expansion of the lungs and an interference with the cardiac rhythm. This causes a maternal asphyxia of mild type, which again lessens resistance and increases the damage to kidneys and liver. Pyorrhea or pyelo-alveolitis should place the attendant on his guard against his patient developing a later toxæmia.

A case of eclampsia will always demonstrate some focus of infection before it develops and that case which even under careful observation up to the week of delivery should show no signs but the trace of albumin, higher blood pressure, and nervous manifestation. In these cases there are evident foci of infection which do not clear up.

Then other cases with temperature manifested before any examination of interference has been done, are in still a third class; usually of multiparae, a number of cases of whom develop toxæmia, having had previous normal pregnancy and labor, but a definite history of infection since the last labor. The bowels should move once daily. This removes excretion products, bacteria and toxins from the system taking stress from the kidneys but saves injury to the intestine which would result from large hardened masses of feces, trying to pass the unusual obstruction and pressure and thus result in infection of the blood stream.

The hematogenous kidney which has been accurately diagnosed and successfully treated by surgical procedure by Dr. Howard Hill, is ample evidence that colon bacilli do gain access to the blood stream and cause infection of the kidney, through infarcts in its deep structure.

Pressure effects on the bowel also disturb the normal balance of bacterial

growth and result in the development of products particularly toxic in nature. Bowels are kept open by fruits, coarse cereals and vegetables, salines when required.

Six and eight glasses of water and milk should be taken daily. These toxæmic patients fare better by eating only one meal a day. Exercise and massage promote general circulation. Hemaglobin should be estimated and iron in the food or by Bland's mass given if needed. The urine should be examined during the first six months once a month; the last three months twice a month. If any symptoms arise examination should be made daily.

The patient is always instructed to notify her attending physician if any danger signals come up unilateral headache, oedema, disturbed vision, epigastric pain or nausea.

The asphyxia raises the blood pressure of the adrenal glands and as a consequence into the blood stream is thrown an extra amount of adrenalin. In consequence of the concentration, acidosis from the increase of acidity results. Associated with this asphyxia and output of adrenalin is the increase in the rise of blood pressure and increased coagulability of the blood. These always occur in eclampsia in the later months.

Now accepting this rational theory of the production of eclampsia, we have tried to standardize our plan of prophylaxis and treatment as follows:

1. Diet which shall be of non-irritating food.
2. Elimination encouraged by kidney, bowels skin. Intake and output of fluids is a most important routine, and must be shown in a daily consolidated report.
3. All foci of possible infection, tonsils, teeth, kidneys and bowels should be discovered and eradicated.
4. Deep breathing aids the general circulation and fresh air avoids danger of asphyxia.
5. Free exhibition of alkali-salts and food anticipates acidosis.
6. Veratrum viride by a system de-

vised to lower blood pressure, reduce the pulse and aid diaphoresis.

The emptying of the uterus as a therapeutic measure to be done in the way least conducive to shock is indicated as soon as prophylactic measures fail. Every one at all familiar with the toxæmia of pregnancy recognizes the marked improvement of the patients condition following the removal of the products of conception.

In a most illuminating paper on toxæmia, J. Young, *Journal Obs. and Gyn. of the British Empire* July 1914, claims that hemorrhages or areas of necrosis in the placenta result, according to whether vein or artery is affected, and that these result from thrombosis in the ovarian and uterine vessels. Toxins are generated in the autolyses of these areas and these Young holds responsible for the toxæmia. This theory placed side by side with that of the infectious origin of eclampsia, recalls the relation of thrombosis and infection, and also the high percentage of toxæmia of pregnancy and accidental hemorrhage where a focus of infection may actually be demonstrated.

Young shows that toxæmias are due to liberation of products of early autolysis of placenta because associated with recent infarcts of placenta which is so constructed that the dying toxins pass directly into the blood stream.

Experimentally, he isolated from the healthy placenta, soluble materials which injected caused convulsions and focal necrosis of the liver, and degeneration of the kidneys.

Most eclampsias occur in primiparae, in hydramnios and in multiple pregnancy. These are, of course, patients subject to the greatest pressure, and most frequently suffer from asphyxia.

It is to be remembered that in chloroform poisoning and the lesions from certain types of eclampsia, the liver and kidneys are identically involved. From this experimental discovery of Arthur Dean Bevan, we conclude that chloroform and eclampsia produce identical injuries, and that chloroform therefore adds to the

danger of the eclampsia and should never be used as an anesthetic. The fact that the asphyxia from chloroform circulating in the blood increases the lesion, suggests that the diet which protects the liver cell in chloroform poisoning should be one generous in carbohydrates, and correspondingly low in fats and proteid.

The identity of the kidney lesion of sepsis and eclampsia have long been observed. Martin Fisher in his work on oedema and acidosis advises the giving of salts which best overcome oedema, as acidosis is quite frequent.

We can see why magnesium sulphate is so often the resort in eclampsia and the reason for its happy results in these cases.

That eclampsia may be due to oedema of the brain is the contention of Zangermeister writing on oedema. In view of the relation of focal infection to eclampsia and preeclamptic toxæmia, great stress should be placed on the locating of all foci of possible infection.

The teeth especially should be examined and these patients should be advised to consult their dentist throughout pregnancy and be under his care. All visible signs of focal infection and destruction must be treated.

If a patient has a history of rheumatism or muscular pains, teeth in which nerves have been killed should be x-rayed. Teeth which have been crowned are especially under suspicion. "Uneasy lies the tooth which wears a crown." The teeth involved should be removed when symptoms of local systemic absorption are observed. To avoid the severe auto-vaccination resulting from the removal, it should be done one at a time. All this is prophylaxis and may prevent toxæmia, hemorrhage and abortion.

Since sepsis is found to produce nephritis in the woman not pregnant how much more likely it is to result in the pregnant patient.

The routine treatment of this group of cases has been milk diet or whey, cereal, sugar and buttermilk, salts until copious results, elimination by liberal quantities

of water, rest in bed, and means of inducing sleep in the pre-eclamptic subjects.

Blood pressure and eye symptoms together with intake and output of liquids are carefully watched and recorded, the latter summed up in 24 hours contrast. If the blood pressure has been persistably over 150 the advent of eclampsia should be expected and if rapid pulse and headache were also in evidence and the pressure remains at 180, the emptying of the uterus has been done. The double benefit of this maneuver is that it not only relieves pressure but it also immediately provides for oxygenation of the child by its own mechanism. A method which will be least shock to the nervous system and least damage to the soft structures of the pelvic viscera should be selected. In general, this is by the Voorhees bag, inserted after gradual preliminary dilatation by Hegar's dilators up to No. 20, which admits the No. 4 bag; rather than by digital dilatation. We have found these patients peculiarly susceptible to sepsis and if forcible manual dilatation is the resort, the cervix being torn into ribbons, not only is the resulting scar an evidence of wreckage of structure but the torn parts of the cervix hanging into the vagina invite septic infection from outside and greatly increase the mortality.

Unless these patients die from results of necrosis of liver or brain, the fatality is usually from sepsis. In fact, the first of the two deaths in the recent series was one due to infection, the patient having been delivered before coming to the hospital. The first seizure was a half hour post partum. Death followed from general peritonitis and myocarditis.

In the Chicago Lying-In Hospital the use of hot packs has been abandoned by Dr. DeLee, but we still are using the electric pack where a dry hot skin with blood pressure of 180 or over indicates the approach of convulsion. Solution of soda bicarb. by mouth or by proctoclysis is depended on as the fluid to preserve an equilibrium between intake and output. All our patients were given ether and in no

case was chloroform allowed—chloral by rectum as a routine sedative is ordered, as it does not produce poisoning as chloroform does, contrary to assertion of some investigators. While an occasional dose of morphine $\frac{1}{8}$ and scopolamin $\frac{1}{200}$ is given, we do not use the Stroganoff method (but if it will remove the danger of nephritis in the non-pregnant, LaVake asks the pertinent question as to why it is not a prophylactic against eclampsia, sepsis, miscarriage and accidental hemorrhage in the pregnant women.) He asserts that he has not seen a case of eclampsia in which a focus of infection and usually a marked one could not be demonstrated.

Krause of El Paso in a paper before the Jackson County Medical Society claims that in all the six eclamptic subjects he has conducted post mortem, the presence of colon bacillus in the kidney was proven, and he associates eclampsia with colon infections, a suggestion to which his laboratory findings give evidence, in his experience.

Hopkins Gardner (Amer. Jour. Obs., 1912) conducted experiments which conclusively disposed of the statement that chloral produces the same liver necrosis as chloroform. He demonstrated also the fact that chloral hydrate produces no histological kidney lesion. We have discarded all anesthetics in the convulsion.

Oxygen in the convulsion has been used as an aid to overcoming asphyxia. No violent efforts should be made to restrain the patient. Magnesium sulphate is used to free catharsis; veratrum to keep pulse under 80. If conscious, give patient chloral 20 grains and bromide 40 grains by mouth; otherwise, by enema, 30 grains and 60 grains.

Murphy drip, soda bicarb. 2 per cent, glucose 6 per cent, should be ordered. If this is rejected one orders soda sol. by hypodermoclysis, care being exercised to have it sterile. Alternately every eight hours high colon irrigation and the hot pack, the latter only if patient is absorbing plenty of fluids.

When all other means fail to free the

system of toxins, we consider the emptying of the uterus as suggested. No bleeding is done, as it has been found phlebotomy is no advantage to the average patient. One cannot tell how much blood the patient will lose at delivery. Blood pressure is much better relieved by veratrum—m.v., m.xv, q four hours for pulse over 100 and m.iii for pulse over 80. Cases not bled recover faster than those bled. Bleeding has done harm, veratrum has never been seen a danger when used intelligently.

With a dilated right heart and beginning oedema of the lungs and high blood pressure, bleeding is certainly indicated. These symptoms absent, it is not.

As against the Stroganoff method of large doses of morphine, we find emptying the uterus more safe. An initial dose of morphine lessens excitement and may be used. When it is used to slow respiration, morphine increases asphyxia and the danger to the patient in consequence. However, Stroganoff has some very wonderful and attractive statistics in favor of his treatment. It is remembered also that several years ago our friend, Dr. Gustav Zinke, of Cincinnati, was visiting the General Hospital and advised "hands off" in a case of eclampsia, saying a certain percentage of these die, regardless of treatment, and he has long been a champion, with Hirst, of the conservative handling of eclampsia, discouraging the emptying of the uterus as meddlesome midwifery. Our results, we believe, justify us in our technique, however.

There is one class of cases which are peculiarly dangerous and in which it must be recognized that the induction of labor or any waiting policy is not to be trusted. This is the fulminating type in primiparae, where one convulsion follows another in rapid succession.

If, in these patients, the cervix is hard and long, the severe effects of continued pounding labor must force the toxins into the blood stream in such violence that her resistance is broken down, through the accession of the toxemia, and the patient

will probably die if she goes over three and four weeks. In case the cervix is not softened, the delivery in this case should be by cesarian section.

Our duty to these women is twofold: First, we want to spare their lives; and, second, the dictates of the Catholic Church as well as those of humanity appeal to us to spare the lives of the unborn children, as well as the mothers, who are imperiled by the overwhelming storm of toxic material which is so rapidly menacing both victims.

Now, having decided to empty the uterus, we have reached the following conclusions as to method. The Vorhees bag is introduced by a technique which has been worked out by the writer, following the example of Dr. Chas. B. Reed of Chicago. We find this means of dilatation less likely to injure the soft structures of the patient or to be followed by shock or sepsis than any other procedure.

If the cervix is not softened, we must choose between accouchement force, a dangerous expedient, producing shock and laceration, thus inviting infection, and on the other hand doing a cesarean section with the added risks involved by the hysterectomy, which are by no means inconsiderable.

In 1916 Dr. Franklin S. Newell of Harvard has recorded the results of 100 cesarean sections within a radius of forty miles of Boston—not from published reports, but from private information—and the startling discovery is laid bare that where patients have been subjected to repeated examination and frequently ineffectual attempts made to use forceps and to do version, and then the section is done, that the mortality is practically 100 per cent. No doubt from such figures that Rudolph Holmes has grounds for his warning against indiscriminate cesarean section as a last resort. It has its place as a selected procedure in certain identified cases of eclampsia and they are limited.

The Vorhees bag introduced by the method mentioned has seldom failed to do good work. We have never had a rup-

ture of the membrane from it, nor have we had a resultant sepsis. The choice of method must of course be determined by the condition of the patient and the experience of the operator.

Prophylaxis and early treatment are the keynote of success. If the patient is under observation early, it is believed that probably brain and liver necrosis, infarcts of kidney, and dangerous sequellae of toxemia, may usually be avoided. Diet: Milk, cereals and fruits should be ordered. Full movements of the bowels are to be encouraged by 1 ounce mag. sulph. and six, eight or ten glasses of water daily, watching the intake and output of fluids.

If symptoms persist, we advise keeping patient in a well ventilated room with sunshine. She is directed to change position; lying, sitting, prone and lateral, knee chest, using calisthenics and massage for exercise.

The dental treatment should be continued at home if necessary.

As a diuretic, imperial drink may be ordered; cream of tartar, dr. 3, sugar of milk dr. 4, lemon juice one ounce, dissolved in three pints boiling water. This, if water becomes distasteful.

If patient tires of milk she may have cereal, whey and sugar diet, with buttermilk. The object of all this plan is to give a high carbohydrate diet, with low fat and just enough proteid to balance and sustain nitrogen equilibrium.

According to experimental research by Opie and Alford, carbohydrates have a favorable influence on both pathologic states from toxemia and chloroform poisoning. Fats have a bad effect, as also has proteid. Wash out bowel daily with 2 per cent soda bicarb. taken in knee chest position; assure plenty of sleep. When the blood pressure, which should be always observed and recorded, remains over 160, the patient is in danger. If it remains over 180 for even a limited period, she is menaced, and at 200 she should be delivered at once.

The albumin index is to be watched, and test tubes kept in series, so the per cent

can be noted daily. If the heat and acid test shows 50 per cent, the patient is considered critical. If it is 85 per cent when first seen the uterus must be emptied if in twenty-four hours tentative treatment with mag. sulph., fluids be tried and if pulse stays over 90 and pressure over 160. It is always to be borne in mind that these patients are peculiarly prone to sepsis and the danger of interference is to be considered. Of course, eye disturbances and heart changes are also positive indications.

The patient with eclampsia two months before her time is very likely to die if she does not clear up symptoms by prophylaxis, and she should always be in the hospital and under close observation.

Concerning toxemic vomiting of pregnancy, five cases have been under treatment. It is a melancholy picture that confronts one looking back to the old empiric plan or lack of plan by which these unfortunate subjects were managed.

The lighter type finally came through, while the more profoundly poisoned victims either had to submit to therapeutic abortion, or they went on to a fatal termination. To Dr. John C. Hirst, who is associated with Dr. Barton Cooke Hirst, of the University of Pennsylvania, is due the credit of the bringing to the profession the value of corpus luteum in pernicious vomiting.

In the list of cases presented here, the first and most suggestive is that of Mrs. C., para, aged 32, wife of an army captain, was seen in consultation with Dr. Lothian at 5:30 p.m. January 16. She came from Camp Doniphan, where she had been under treatment which was unsatisfactory because of the lack of laboratory facilities and proper food as well as hygienic means to combat the toxemia. On entering the hospital the patient presented a pathetic picture: Semi-conscious, general edema which invaded the larynx and the glottis and caused a whistling breathing resembling a child with croup, amblyopia, unilateral headache, epigastric pain, nuchal pain, blood pressure 240 m.m. of Hg., pulse 122, urine loaded with albumin,

hyalin and granular casts, scanty and of heavy specific gravity.

After salines the bowels were emptied and the blood pressure was reduced by veratrum viride m.x. to 186 and the pulse to 96. She had a comparatively quiet night, but on January 17 her urine showed albumin 4+, but neither hyalin nor granular casts. Blood pressure went up to 200 and pulse to 102. Veratrum m.x. was followed by a drop to pulse 86 and blood pressure 178. No headache, but patient was perspiring profusely. At 9 p.m. another 10 m. of Veratrum and the blood pressure recorded was 122 and pulse 68.

The bag was placed at 6:30 a.m. and pains began at 10:30. The cough from the edema of glottis returned, and patient resumed retching and vomiting and became very restless. Veratrum m.10 was given, and the recorded blood pressure 132; at 12:40, noon, the blood pressure was again 196, and at 2:30 Veratrum m.x. was followed by blood pressure 150. Pains every three minutes and lasting thirty seconds. The bag was expelled at 2:50. At 3:10 a hypodermic of morph. sulph. $\frac{1}{8}$ and scopolamin $\frac{1}{200}$ and at 3:35 the recorded blood pressure was 138. She was delivered at 4:52 when the blood pressure was 150, pulse 66, foetal heart 152.

The placenta was sluggish as it is apt to be in these cases, and was expelled after $\frac{1}{2}$ c.c. of pituitrin at 8:45 p.m. The pulse, after ether, was slow and, as usual, perspiration profuse. No veratrum was recorded again until the 19th. The baby, which weighed $5\frac{3}{4}$ pounds and was at the seventh month, was kept alive by the breast milk of other mothers in the hospital, but finally expired in the third week, evidently from effects of maternal toxemia which it could not throw off. Vision gradually was regained and Mrs. O. could distinguish persons and colors after the tenth day. The blood pressure fluctuated between 130 and 180, pulse averaged 90 and respiration 20. She left the hospital February 6. On March 30 Mrs. O. called at the office and requested permission to return to Camp Doniphan to remain until her husband should start over

seas. Vision was good. No headache nor other disturbances. Both Capt. and Mrs. O. called on April 30. She was apparently well.

CASE No. 2.—The wife of Dr. P., aet. 26, para 1, had been under observation throughout her pregnancy. At various times albumin and casts appeared; eye symptoms, epigastric pain, general edema, unilateral headache and all the classical indications of eclampsia, but at no time over two of these appeared simultaneously and at no time any rise of blood pressure over 130. She readily responded to restricted diet. Her delivery was uneventful and no toxic symptoms have appeared since return home. The daughter is a healthy specimen.

CASE No. 3.—Mrs. N. C., came from Toledo, Ohio, and was seen in consultation with Dr. Buford G. Hamilton; para 1, aet. 38, blood pressure on admission 138, headache, spots before the eyes, ratio of intake to output of fluids, 1:63. Had short breath, epigastric pain. Bag induction was done on fourth day after prophylaxis was begun. A living baby was born voluntarily after twelve hours labor. No convulsions were experienced. On dismissal blood pressure was 124; ratio of output to intake less than 1, patient has since reported in good condition.

CASE No. 4.—Mrs. J. E. P., aet. 23, para 1, the wife of a young railroad contractor and daughter of the president of one of our great hospitals, had been a patient from the beginning of her pregnancy. Several times she showed trace of albumin and on that account she was on a restricted diet throughout her pregnancy. Her blood pressure ranged between 110 m.m. and 120 m.m. and she was always apparently in good condition with the exception of the albumin. The urine was examined and found negative on Friday and her blood pressure which was taken, measured 120. Saturday forenoon Mrs. P. called up and reported a headache, for which phenacetine was ordered by telephone and the patient requested to report her condition by evening. At 6:30 the telephone rang and report came that Mrs. P. had fainted while at

dinner. On reaching the house in fifteen minutes, she was found on the floor of the dinning-room, unconscious and limp. No history of any convulsion seizure could be elicited, but the family was at once warned that she was in imminent danger of spasms and while a mouth gag was being improvised from a clothes pin and a napkin, the first seizure occurred. The ambulance was ordered and responded immediately. Meantime the patient was gotten to bed and in twenty minutes had the second spasm. She was in the hospital in forty-five minutes and a rectal examination having found a long hard cervix—no sign of labor, blood pressure 200, patient still unconscious, an urgent cesarean section was decided upon and done by Dr. B. L. Sulzbacher. The patient made a very gratifying recovery and the baby was at no time apparently disturbed by the precarious experience of his mother and both patients are now normal.

In this case the long hard cervix, the fact that three convulsions came out of a clear sky in less than an hour, and the almost complete suppression of urine, led to the conclusion that a section was the only chance for a living baby, and gave the mother the greatest advantage, by early relieving her from the burden of oxygenation the fetus at a handicap, and also did away with the toxic foci which the placenta and the fetus doubtless constituted.

CASE No. 5.—Mrs. J., para 1, pregnant five months, wife of a minister, referred by Dr. Clark of Wichita, was under observation for six weeks and no abnormal indication, blood pressure normal, urinary findings negative and an ideal case seemed ours until one night a violent headache developed and symptoms of eclampsia and abortion developed. Dr. Harry Jones was kind enough to see the patient in Rosedale, as the writer was engaged in another case. She was given a hypodermic and sent into the hospital. The following picture presented itself: Blood pressure 220, patient unable to see; pulse 110, urine loaded with albumin, both hyalin and granular casts;

right unilateral frontal headache, epigastric pain, general oedema, cough and vomiting.

Magnesium sulphate and veratrum were at once administered and the patient put into a hot pack. Blood pressure dropped to 160 and pulse to 60. After three days patient was running a pulse of 90 and a blood pressure of 160 to 180 and the indications were that the fetus was dead, no fetal heart nor movements being found after repeated examinations.

The Vorhees bag was placed as the best means of emptying the uterus and labor followed in sixteen hours; a still-born female infant at the sixth month being delivered. No further convulsions were suffered and the patient went home on the eighteenth day, apparently free from evidence of toxemia. A recent report gives her condition as quite satisfactory.

CASE No. 6.—Mrs. S., aet. 32, para 4, wife of a lawyer at Webb City, Mo. came, November 15, 1917, for her fourth confinement as at each of the former, with a toxemia headache, visual disturbance, blood pressure 145 m., urine showing albumin, hyalin and granular casts. Neuralgia of the face which was traced to a pyorrhaea, resulting in infection and absorption which was relieved by extraction after X-Ray picture showed the necrosis.

As the pain and edema with insomnia persisted, the patient was sent to the hospital—McDonald 36, blood pressure 150. Induction was done at 9:30 p.m. and pains began at 10:20. To delivery room at 11 and labor terminated, patient back in her room at 12:15. Two hours and three quarters. Symptoms all cleared up and patient returned home in three weeks. Is now apparently well.

Miss M., aet 16, para 1, was seen at St. Vincent's Hosptal where she had been for six months, the last two months under the care of Dr. B. G. Hamilton. McDonald was 33, blood pressure 170, urine showed albumin, hyalin and granular casts. On account of her religious convictions no active treatment was instituted. She was in labor forty-four hours with a R.O.P.

and finally delivered with forceps of a fetus weighing 5½ pounds. The patient was thoroughly exhausted. She left the hospital still showing hyalin and granular casts. Undoubtedly the bag induction would have spared her some of the long suffering.

Mrs. B., para 1, aet. 42, came into the hospital at the sixth month, having had false pains which were quieted by morphine. Her blood pressure was 120, urine findings negative. She left the hospital with friends and took an automobile ride in the afternoon. At 3 a.m. she went into convulsions, having three before re-entering the hospital and two after. With a long hard cervix and no softening it was decided to do a cesarean section. The uterus was studded with small fibroids. The patient made a perfect recovery. After two weeks she had no symptoms. The baby lived six hours.

Mrs. E., aet. 30, para 2, entered St. Vincent's with a blood pressure of 240 which had continued for six weeks. Daily examination showed no trace of albumin nor casts. The day before delivery, which was normal, a trace of albumin appeared. Her treatment was mag. sulphate and veratrum, which did not effect the height of blood pressure. She was delivered of an eight-pound baby and left the hospital with normal blood pressure, and no pathological urinary findings.

Mrs. D. aet. 22, para 1, came from Colorado and entered the hospital April 8, 1918, under care of Dr. B. G. Hamilton. Her blood pressure was 200. She had marked disturbance of vision. Her specimen of urine a week before had been negative and blood pressure 124. She thought the visual disturbance due to the fact that she had broken her glasses and the edema due to the pressure from the uterus. We found her McDonald 36 and her history showed her to be at term. She was given the usual prophylaxis, put into a hot pack, the pains began voluntarily and she delivered herself with no artificial assistance. The blood pressure fell to normal and remains unchanged. Urine

is negative but she still complains of some headache.

Mrs. B. aet. 26, para 2, was seen with Dr. Hamilton, March 25. One week before the doctor found albumin but no casts in the urine and a blood pressure of 120. On admission the blood pressure was 180, pulse 90, urine showed albumin, hyalin and granular casts and was scanty. She had right unilateral headache, red spots before the eyes, epigastric pain. Blood pressure rose to 190. An induction was done after prophylactic treatment failed to hold the symptoms in check. After the bag was placed the blood pressure dropped to 150. She was delivered in eight hours. Both mother and child left the hospital in good condition. On examination the baby's urine showed albumin for three days, as it has in many of these cases. No albumin in urine of mother or child on discharge.

Mrs. A. aet. 24, para 1, entered the General Hospital at the sixth month of pregnancy, passing one pint of urine in 24 hours, showing albumin, hyalin and granular casts. After diet and prophylactic treatment the patient went home, all symptoms having subsided; nor did they return. At term she came into the hospital again and delivered herself voluntarily without symptoms of toxemia. This patient had previously undergone two surgical operations, an appendectomy and a fixation.

Mrs. L., aet 24, para 1, at term, L.O.A. McDonald 36, was seen in conjunction with Dr. G. A. Droll. Patient entered the hospital with a blood pressure of 190, pulse 100 and normal temperature. Her intake and output were of normal relation. Headache and spots before the eyes, general edema and nausea completed the series of symptoms. After mag. sulph. ̄ s.s. and enema of soda bicard. sol. 2 per cent pressure dropped to 150 but it went back to 190. Restricted diet and repeated doses of veratrum failed to hold the blood pressure and it was resolved to induce labor. The patient was slow to respond and not until twenty hours was good labor inaugurated. Delivery was effected and

symptoms at once relieved. Patient left the hospital in good condition at the fourteenth day. Involution complete and no symptoms of eclampsia.

Mrs. S. K. para 4, came into the Ward Three, the maternity department of the General Hospital, March 12, 1918, after having had 12 convulsions and being comatose, edematous, blood pressure 240. Hot pack, veratrum and magnesium sulphate were at once utilized and symptoms subsided. The patient was discharged March 31 in good condition. Dr. Hamilton recognized the patient as having been seen twice in her home in eclampsia. All the babies were born alive.

* CASE NO. 6.—Mrs. G., para 1, aet 42, in eight month was referred by Dr. E. Miller of Liberty. She was admitted at 4 a.m., coming by ambulance from her home. Patient was having convulsions in rapid succession, had general edema, which invading the glottis gave her a breathing resembling a child with croup. Her blood pressure was 220, pulse 120, and temperature 101.8. No labor was yet inaugurated, no fetal heart nor fetal movements could be ascertained. The routine induction of labor by Vorhees bag was done after veratrum m.x. croton oil, m.ii. by catheter into the stomach and sol. mag. sulph by gavage, also. Veratrum was repeated at 6 a.m. and blood pressure dropped to 160; at 7 it was 190; at 8, 180; at 9:15 it was 195. Veratrum at 9:15 and blood pressure at 10 was 185, at 11 it was 200, and at 12 no change. At 1, after the hourly exhibition of veratrum, it dropped to 140. Vision was dim, although patient was now rational. Vomiting and convulsions were persistent. Proctoclysis of soda bicarb. 2 per cent and glucose 5 per cent was given. The 24-hour intake was 1330 c.c. and output 550 c.c. At 6:45 a still-born fetus was delivered, weight 5 pounds 6 ounces. The placenta was delivered at 10 o'clock. Her blood pressure ranged from 160 to 220 after the delivery, intake and output would stand 1700 c.c. to 1640 c.c. whereas before delivery output was only one-third of recorded intake. Sodium phenolphthalein

test for efficiency gave a very slow response. On November 17 the patient was up in a wheel chair, very cheerful, and invited the doctors and nurses over to Clay County for a chicken dinner. Her pulse was 88, 68, and 76, blood pressure 180; intake 1860, output 1600 c.c., apparently convalescent and prepared to return home next day.

Without warning the blood pressure went to 200. Kidney secretion was completely suppressed, the patient became comatose and expired. Evidently a case of eclampsia, grafted on a chronic nephritis.

CASE NO. 7.—Mrs. P., para 1, entered hospital February 26, with a blood pressure 180, urine showing albumin hyalin and granular casts. She was given mag. sulph., and a sweat with large quantity of fluids and the blood pressure remained between 160 and 190, albumin constantly increasing, vision much impaired, vomiting and diarrhea persistent. She was prepared for a Vorhees bag induction, which was done on March 1. Labor set in in four hours and patient was delivered in nineteen hours voluntarily. She left the hospital the third week, no symptoms showing, but slight albuminuria.

CASE NO. 8.—Mrs. J. B., para 1, aet. 25, admitted March 31 with blood pressure 200. No other symptoms. Went into labor voluntarily, was given veratrum m.x. and magn. sulph., delivered herself after three hours, her blood pressure fell to 160, in 5 hours to 130. The urine on admission showed albumin 4 plus, diacetic acid and indican. Her recovery was uneventful. On dismissal blood pressure stood 118 and pulse 90.

CASE NO. 9.—Mrs. H. S., aet. 26, para 1, was admitted February 17, 1918, at 2 a.m., having been delivered at home, by Dr. W. M. Sams, who was her attending physician, and who was associated throughout the case. She developed convulsions three hours post partum. Eight convulsions were suffered before she reached the hospital, unconscious, blood pressure 150, pulse 100, temperature 103. The patient

improved under the routine treatment. Became conscious and was apparently convalescent when symptoms became exaggerated, peritonitis developed and a septic myocarditis. A severe ophthalmia had sprung up affecting the left eye, and the pus being cultured gave a positive Neisserian reaction as did also the vaginal discharge.

Doubtless the septic myocarditis from which she finally succumbed could be traced to the Neisserian infection, proving as Dr. La Vake maintains that all eclampsias may thus be accounted if we can but find the source.

CASE NO. 10.—Mrs. H., para 1., a college woman, aet 34, was seen in consultation with Dr. Buford G. Hamilton. She entered the hospital April 18, 1918 and although seen frequently at home with no evidence of toxemia though she had slight headache or some difficulty in sleeping, it was found on admission that marked symptoms of eclampsia were in evidence. Blood pressure was 200. Unilateral headache, disturbed vision and insomnia were marked. The blood pressure dropped to 160 and ranged back to 200. Patient became very restless, as well she might, carrying the burden of an eclampsia, a right occipitoposterior position, added to a mitral heart lesion, and a salpingitis. Labor was induced and the patient was having pains every two minutes and lasting a minute. The bag was expelled and dilatation tolerably well established, but rotation had not taken place when the patient had a terrific convulsion lasting two and a half minutes. She was at once put under ether anesthesia and delivered by Dr. Hamilton by version but the baby was still-born, evidently the result of the maternal toxemia and the convulsion. The mother is today apparently convalescent, blood pressure 124, no symptoms of toxemia.

The most remarkable of the cases of pernicious vomiting is that of Mrs. T., the wife of a mining engineer of Bartlesville, Okla., who had twice before been a patient, and each time it was found necessary to empty the uterus after an ineffectual trial

of means at hand to relieve her condition by less drastic measures. Being especially anxious for a child and after such an experience Mrs. T. came to the hospital last summer, was put to bed for the month, second month of her pregnancy, just as the nausea and vomiting seemed to become intolerable. She was given bromide of soda 5i and chloral gr. xxx by enema to quiet the nervous excitement. Afterwards reducing this dose to ℥ii of bromide and ℥i of the chloral p.r.n.

The corpus luteum was given by hypodermic $\frac{1}{4}$ c.c., on alternate days with $\frac{1}{2}$ c.c. thyroid extract on the succeeding day. This dose was increased to $\frac{1}{2}$ c.c. of the corpus luteum and as the effect of the thyroid or her pulse indicated the latter hypodermic was abandoned. After two weeks the vomiting ceased and the patient returned home. Went through an uneventful pregnancy, came back to the hospital and was delivered at term of a perfectly normal boy baby and made a good recovery.

Mrs. G. from Englewood had been in a hospital for three weeks, given morphine and other sedatives unavailingly and returned home. Her mother who had been a patient in her own lying-in days, brought her to the office, and it was decided to put her on the corpus-luteum regime. At the time of admission, the only article which was retained at any time was soda pop, of which concoction many bottles were consumed. Many times this was rejected but no food or drink otherwise was retained even for an instant. In two weeks she returned home after the corpus luteum and thyroid, and was delivered at term, now apparently well.

Two cases at the General Hospital followed the same history and with equal results.

On March 12 Mrs. J. G. L., of Okmulgee, came into the hospital, having been referred by Dr. Mitchener, of Okmulgee. Her history as to pregnancy was that she was delivered of a girl baby ten years ago, after a stormy pregnancy, the vomiting at times threatening to overwhelm her. Twice subsequently under the care of two differ-

ent medical attendants, she was relieved by therapeutic abortion which cleared up the symptoms.

The present pregnancy began in a storm of nausea, from which the patient had no relief. She was in bed for four months, coming to the hospital thoroughly exhausted. She was unable to raise her head from the pillow. Vomiting was continuous and some pain was felt, which had caused such alarm that a doctor was called to the train at Vinita, on the way up, and a hypodermic injection of morphine was administered.

Her blood pressure was 115 but some edema was present. The urine was loaded with casts and albumin and blood persisted in each specimen for the first week.

Under a restricted diet, absolute rest in bed, corpus luteum and thyroid ext., bromide and chloral by enema to quiet nervous excitement, the patient gradually improved and she is at this writing able to eat what she desires, is up and about having left the hospital to remain at the Muehlebach Hotel until her accouchment in May.

The remarkable series of cases, while it is only five in number, is all that have been met in the past year, so it is 100 per cent success. Of course, one admits it may have been good fortune that these results were obtained, but it must be remembered that it included the cases in series and what is of more importance in two of them, abortion was done twice before because it was feared the life of the patient was in grave jeopardy.

Some better plan may be devised for treating this type of toxemia, but up to the present it is certain that none has produced in the hands of the writer, such signal success in results.

It would be a needless waste of your valuable time and simply a repetition to further enumerate the cases which go to make up this very remarkable list which now reaches the number of forty-six individual instances of pregnancy toxemia since May 1917, twenty-three of them since January 1, 1918.

One can hardly see how such an experience as this can be accounted for except as has been said to ascribe the prevalence of these toxemic explosions to climatic or atmospheric loss of equilibrium, as has been claimed by our friend Dr. E. Miller, of Liberty, former president of the Missouri State Medical Society, who some years ago read a paper before the State Society on Epidemic Eclampsia, and who recently told the writer, as an evidence of epidemic herpes zoster, that he had in the past winter seen and treated nine cases of shingles, in his own practice. Whatever opinion one may hold as to the etiology of these toxemias, one can but be struck by the results of a system of routine examination, laboratory reports, including urinalysis and the estimation of kidney insufficiency by the sodium phenol phtalin test which is now being done as a routine, the careful record of intake and output of fluids and blood pressure carefully watched. Treatment by veratrum, magn. sulph., hot packs and plenty of fluids has been in comparison with other systems of treatment gratifying in that the system has been unusually satisfactory. Furthermore the Vorhees bag in the hands of the writer has demonstrated itself perhaps a hundred times in the last year, as the conservative and safe instrument for inducing labor with the least shock, greatest accuracy and most generally safe results.

Still further, it is impressed on us that in spite of Stroganoff, and the weighty endorsement of such eminent authorities as our friends Dr. Barton Cooke Hirst and E. Gustave Zinke, these patients are not free from menace to their lives until they are delivered and the source of the toxins removed.

The results here obtained could not have been had in the home of the patient and it is emphasized most strikingly by these toxemic cases as well as by the other obstetric emergencies that the only ideal environment for their protection is that of the hospital.

To Summarize:

Toxemia of pregnancy and eclampsia are due to change of metabolism resulting from faulty proteid and fat, from an undertermined toxin, from the growing ovum resulting in infarcts and other pathological changes, kidney, liver, thyroid, brain and spleen. These toxins are thrown into the blood stream, the products of autolysis of placenta infarcts from which dying particles are carried to the kidney, liver etc, and cause focal necrosis.

Hyperthyroidism is only an incidental evidence in the vicious circle.

The extra burden on the mother to throw off this poison, and the oxygenation of the fetus, overwhelms her resistance. Especially may this result in alternating extreme cold weather and mild days, she being unable to stabilize her powers of resistance. A loss of equilibrium between centers and periphera of the body causes an acidosis, because of the unstable condition of the metabolism. Failure of elimination results in stasis, decreased maternal oxygenation, lung expansion, and heart action are disturbed, asphyxia results, foci of infection, teeth, tonsils, colon infections may usually be demonstrated in toxemia. Adrenalin output is increased, blood pressure raised and blood coagulation abnormally increased in toxemia.

Consequently prophylaxis including diet, bland foods and plenty of fluids; elimination by mag. sulph and sweats, eradication of foci of infection are to be planned. Asphyxia is avoided by deep breathing and fresh air. Acidosis is anticipated by alkalies. Blood pressure is reduced by veratrum, not by phlebotomy.

All other measures failing, the final resort is to empty the uterus. This should be under ether anesthesia. Ether being the only safe inhalation anesthetic in these cases.

Technique which involves least shock. Preliminary dilatation gradually by Hegars dilators up to No. 20; Vorhees bag No. 4 if at term—introduced by Reed's method—cigarette roll, held by Paens forceps. Gavage of soda bicarb. 2 per cent after uterus is emptied.

Cases of the fulminating type—long hard cervix, in which no vaginal examination has been done, are best treated by classical cesarean section.

When after contamination by frequent digital examination, infection is almost surely to be expected. A Poro or other hysterectomy should be done in the interest of the mother. (See Franklin Newell's statistics of results near Boston.)

A woman without a uterus is better than an anatomical specimen.

The results in the series of cases from which these conclusions are drawn showing 95 per cent recoveries of mothers and of the children at term—our mortality 1.5 per cent—at least warrant the belief that since Tweedy's tables showed maternal mortality of 8.1, DeLee 20, Williams 25, Cragin 28, N. Y. Lying-In, 30, the average American 38, the Royal Maternity of Edinborough 66, these figures being from DeLee's Year Book 1918, that our results are far above the average or else our cases have been less toxic than those encountered elsewhere, which is not likely to have been the case.

From our own experience and from that of other observers, including a most interesting report just received from Dr. Ben Myers, who does a large obstetric work in Alaska and who finds that in the last year, an unusually cold wet season, 12 per cent of his cases suffered from toxemia, the conclusion is drawn that the weather does at least aggravate the tendency to this condition. As there is such a close relation between the toxemia and the nervous system, is it not also fair to ascribe to the war an incidental effect as a causative factor?

The moral to be drawn is that pregnancy is a condition in which the patient is peculiarly susceptible to external influences of cold and damp and more especially during the war owing to psychical impressions disturbing the nervous equilibrium, she should be inspired by a cheerful optimism that we are going to win the war and make the world safe for future generations of freeborn people.

Hyaloid Reflexes and Their Clinical Significance.

E. J. CURRAN, M.D., D.Oph. (Oxon)

Professor of Ophthalmology, Medical School,
University of Kansas.

In the literature for more than ten years past little is to be found concerning certain reflexes of the fundus which have been attributed to the retina, but which in reality belong to the hyaloid membrane. These are the so called water wave reflexes occasionally mentioned in text books and generally considered to be normal, especially in young people. An adequate study of these reflexes will not fail to reveal that they are often pathological, and of great clinical significance, whether in great abundance, special arrangement, or even in total absence or diminution of the number and extent. In order to have a clear conception of the value placed upon them it is necessary to be clear as to the origin of the reflexes and to know what may be expected in the normal eye. Various theories as to their origin have been suggested, such as unevenness of the sclera, folds of the retina, or parts of the retina, but no one seems to have considered the hyaloid membrane as being their cause. They have been attributed by many to the superficial layers of the retina. The hyaloid membrane which is of mesodermic development cannot be said to be part of the retina. Its existence was at one time, but is no longer, a matter of dispute. It can very easily be demonstrated in microscopic specimens by Wright's differential connective tissue stain, which shows it as a blue line immediately internal to the retina. It is important for clinical purposes to realize its embryologic development, and from this it is quite clear that any reflexes arising from it should not be called retinal reflexes but simply hyaloid reflexes.

I shall now endeavor to show that both the "water-wave" or "shot-silk" reflexes and the macula reflexes arise from the curved surface of the hyaloid membrane;

but first we must dispose of the theories that they may arise in any part of the retina or sclera. The macula reflex is perhaps the one most frequently referred to, and small as the subject might seem, an adequate study of this reflex is far beyond the scope of this paper, and cannot be taken up without going deeply into many pathological conditions of the retina.

It is probable that the consideration of the macula reflexes, taking place, as it does, in the region of a retinal depression, caused a recent writer to attribute other reflexes to an unevenness of the retina.

It does seem, when we reflect upon the following observations, that a wrinkling of the retina alone cannot produce retinal reflexes.

First: In the condition described by Patton, following optic neuritis in which there were vertical folds of the retina, there are no vertical reflexes corresponding to them although there may be vertical hyaloid reflexes.

Second: In a case of choroidal detachment after an Elliot operation for glaucoma at the Bell Memorial Hospital, in which the choroid and retina became re-attached, leaving the transverse folds five D. D.'s above the optic nerve and about two D. D.'s in length, there were no retinal reflexes in the fundus but there were hyaloid reflexes in the vicinity, which did not correspond to the folds in the retina and were seen to pass over a vessel in that region.

Third: Folds on the edge of the optic disc do not give reflexes.

Fourth: In case of a well advanced hemorrhagic retinitis observed at the eye clinic of Kansas University Medical School in which the disc was almost choked and there was much venous congestion, there were innumerable folds in the retina as proved by microscopic sections after removal of the eye, but there were no retinal reflexes.

Furthermore, the anatomy of the retina does not lend itself to light reflections in such a manner as to produce a fundus reflex of a glistening water wave appear-

ance. The external limiting membrane is too much perforated by rods and cones to make a good reflecting surface. Unevenness in the sclera is an explanation too far drawn to be convincing, and there is no anatomical basis here to account for some of the sharp movable reflexes seen. The nerve fibers are closely packed together and one might imagine that this layer would be smooth enough surface to give such reflexes, but it is not so. One cannot find reflexes on the optic disc, where these fibers are closely packed together and in folds as they turn into the nerve head on the nasal side. A surface must be very fine and glassy in order to produce reflexes. Only the hyaloid membrane affords such a surface. It is a delicate membrane lying moderately close to the retina, sending here and there some very fine prolongations into, and becoming continuous with the fine meshwork of the vitreous. In its covering of the retina, it is approximately uniform in thickness, but as it approaches the optic nerve, it becomes thinner, and on the optic disc, breaks up into sparse network, which in some cases can be seen to come forward and to form the walls of the hyaloid canal for a short distance. Where vessels lie on the retina, it passes over them, forming a partial meshwork sheath suitable for a receptacle for lymph or the flow of exudates. In microscopic sections it is always lying in some more or less irregular folds, which are, for the most part, caused by the shrinkage of the retinal tissue due to the hardening process in preparation of the specimen, but at times they show remarkable regularity and no doubt in some cases are to be thus found in life. In some sections, which pass through the macula, the hyaloid membrane is to be seen hugging closely the anterior layer of the retina with no folds and no prolongations into the vitreous in this region, but there is evidence that in some cases there are sub-hyaloid spaces here as elsewhere in the retina. In short, a close study of the structure of the membrane and its relation to the retina

establishes the fact that it is capable of producing a space between the vitreous and the retina, which contains a fluid which may or may not at times be of a different refractive index from that of the vitreous, and that this membrane, together with the fluid it contains, is capable of producing the so-called retinal reflexes. We shall see later that these may be present in disease or in health, but there are certain marks by which we may know of the existence of a pathological condition, present or past.

Any disturbance of the hyaloid reflexes must be attributed to some process taking place behind the hyaloid membrane and, as has been stated above, we should by careful study of every case, endeavor to become familiar with the limits of variation of the normal hyaloid reflexes. Since these variations are very great, this is not an easy accomplishment. Moreover, since these reflexes cannot be successfully depicted by the artist, and are extremely difficult to describe, it becomes essential that the student should learn to know them from the fundus. They are best seen with a uniform illumination from a reflecting ophthalmoscope. In some eyes, especially in adults, they are entirely absent. When present they are to be seen mostly about the vessels, and if the light is wiggled carefully they can be seen to pass over the vessels which is another proof that they belong to the hyaloid membrane. In the main they radiate more in the direction of the vessels. Occasionally, a delicate uniform reflex can be seen almost all over the fundus which reflects but little light and is rather difficult to see as a reflex. Then at times this will partake of the water wave silk variety. In early retinitis the region of the macula may have water wave reflexes and also reflexes of a similar nature which are vertical in direction between the disc and the macula. Later these may become horizontal in direction and remain thus for months or years after the retinitis has subsided. I look upon these vertical or horizontal reflexes in this region as

evidence of either a retinitis which has subsided or one beginning. In early retinitis of the serous type one often finds a reflex at the macula and around it spreading below for a considerable distance, which gives one the impression as if coming from a small pool of water spreading under a thin membrane. These pools may be seen elsewhere in the retina. The normal macula reflex may be seen as a small spot of light in the center of the macula and standing out from it apparently two or three millimeters. This spot of light can be made to move by altering the direction of the illumination. The apparent distance it stands in front of the macular depression depends on the curvature of the macular depression. Sometimes this spot of light has a comet tail-like prolongation which can be made to go around like the hand of a clock in either direction by throwing in the light in various ways. Another form of macula reflex is the discoid kind which is less bright and has an apparent diameter of one, two or three millimeters, and is more transparent than the spot of light above referred to. A rarer kind of normal reflex has a ringlike appearance. Finally, there may be a diffuse macula reflex fading away from the macula. Again, there may be no demonstrable reflex at the macula. Any variation from these in general means something pathological. Pathological variations take the form of broken reflexes, and any diffuse broken reflex at the macula is often associated with diminution of vision and means that there is, or has been a diffusion of fluid under the macula hyaloid. At first this broken reflex may be stellate and afterwards become a diffusely broken reflection of light. These reflexes have been studied at the University of Kansas eye clinic for the past three years, and this study has thrown much light on many obscure cases, and it is the hope of the writer that they may be given much attention by other oculists. It is regretted that the full value of these observations cannot, on account of space and difficulty

in description, be given in this short paper.

—R—

Maize Oil.

E. W. Rockwood and P. B. Sivickes, Iowa City, Iowa (Journal A. M. A., November 16, 1918), have investigated the relative digestibility of maize or corn-oil, cottonseed oil and lard, by experiments on dogs. Corn-oil has been placed on the market in this country the last few years under various names, hence the desirability of the study of its digestibility. The dogs represented three types: one normal in development and vigor; the second in sub-normal condition, and the third, excessively fat. "As their weight did not differ materially, the same ration was used for all. It consisted of 40 gm. of cracker meal, 10 gm. of bone ash and 155 gm. of chopped lean beef, freed from visible fat as much as possible. In a fore-period, no fat was given and the ether-soluble material was determined in the feces and regarded as the 'normal' output. In the fat periods, 40 gm. of the fats tested were included daily. The feces were marked off by lamp-black, dried after addition of alcohol-acid and extracted with dry ether in the usual manner." The results are tabulated for each type, as well as the percentage of fat metabolized. If the total amount of fat is used, neglecting that of the feces on the basic relation, the digestibility will seem apparently lessened, but the relative digestibility will be the same. This may be due to the difference in the melting points. Other experiments, which need not be detailed here they say, show that corn-oil can be well substituted for animal and other vegetable oils in salads, and for shortening in cooking wheat foods.

—R—

Influenza Vaccine.

So far but two definite reports of adequately controlled experiments on the use of influenza vaccine appear to have been published. That of Barnes concerned the use of the Leary vaccine, composed of strains of the influenza bacillus, and indicated that the vaccine was not of prophylactic value. The second report, by G. W. McCoy and co-workers, concerned a carefully controlled experiment on the use of a mixed vaccine similar to that brought out by Rosenow, and indicated that this vaccine was not efficacious as a prophylactic against the present epidemic (Jour. A. M. A., Dec. 21 1918, p. 2094).

THE JOURNAL

of The

Kansas Medical Society

W. E. McVEY, M.D. - - - - Editor

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State Medicine.

To what extent shall the State be responsible for the health of the people? To what extent shall it provide care for its afflicted population? These are questions to be determined only when our civilization has reached its ultimate of perfection. Even a casual consideration of our state and national history must suggest the inevitable enlargement of the State's interest in the health of its people.

Upon the same basic principle underlying our laws providing for the incarceration of criminals lies the justification for the State's intervention in the prevention of disease, and ultimately in the care of those afflicted. While guaranteeing all the privileges of citizenship in a great republic, the State has reserved an exclusive prerogative, under the broad and expansive term police power, capable of wide interpretation, by which it may ignore the rights and privileges, the interests or the liberty of an individual or individuals, when the life, safety, health or happiness of the people is endangered.

In spite of the fact that our penal laws provide prison sentences as punishment for crime, and in spite of the fact that our criminologists have endeavored to make

reformatories of these prisons, the State's justification for the incarceration of a criminal lies in the fact that the people are thus protected against any injuries which the criminal at liberty might inflict.

In spite of the fact that the institutions for their confinement are called asylums and hospitals rather than prisons, and in spite of the fact that facilities for their treatment and cure are now the predominate considerations in the construction of such institutions, the State's justification for the arrest and confinement of insane persons lies in the fact that thereby the people are protected from the irresponsible acts of the mentally deranged.

It is the same principle that justifies the existence of our reformatories and our homes for the epileptic and the imbecile.

The regulation of the practice of medicine—the enactment of laws establishing a standard of qualifications and providing for the licensing of those who wish to practice medicine is a just exercise of its exclusive prerogative by the State.

The Board of Health was created as a department of the State and to it has been delegated the exercise of those police powers pertaining directly to the health of the people. These powers have been enlarged and expanded as wider interpretations were justified by more accurate knowledge of the causes of disease and the means for their prevention. How rapidly this expansive process has developed may be estimated by comparing the early quarantine of small-pox cases, when high board fences and armed guards were required, with the quarantine methods of the recent plague epidemic, when not only the afflicted were confined, but churches, schools, factories, business houses and street cars were closed or restricted in their operation. In this most extensive exercise of its police power the State was justified in that by such methods was the safety of the greatest number of the people provided for.

Step by step has the State's interest in

the health of its people increased and the scope of its intervention widened until the care of every diseased or afflicted person, who might be a menace to the safety of the people, and the care of every disease known to be, or believed to be, contagious comes under the supervision of some of its departments.

The last step in the expansive process has been taken with unerring direction, but with slippered foot and stuttering movement, for one one cares to discover the social upheaval that would probably be occasioned by a strict quarantine of venereal diseases. The same basic principle which justifies the State's intervention in the prevention of small-pox, diphtheria and other contagious diseases, more fully justifies its intervention in the prevention of venereal diseases. From the point of view of its disfiguring effects or its mortality, small-pox is insignificant when compared with syphilis and gonorrhoea. One may therefore anticipate the State's gradual, but finally complete intervention in the control of venereal diseases.

The same factors which have constantly augmented the scope of the State's activities in the field of medicine will continue to operate. It is but a step from the incarceration of the criminal for public safety to the inauguration of reformatory methods which will restore him to useful citizenship. It is but a step from the confinement of the insane to the curative measures which tend to hasten the safe restoration of their liberty. And it is but a step from the restraint of those afflicted with contagious diseases and the imposition of certain sanitary measures in their care, for the safety of the public, to a complete supervision of their treatment, if by such measures the period of public menace may be reduced to a minimum.

As our knowledge of the etiology of disease becomes more definite and certain, so will the police power of the State be more liberally interpreted, and the scope of its application be more widely extended.

With even a casual consideration of the rapid expansion of the State's activities

in matters of public health one must anticipate a complete supervision as its ultimate attitude toward the practice of medicine.

—————R—————

Lung Abscess Following Tonsillectomy.

Beven, in the October number of Surgical Clinics, reports several cases of lung abscess following tonsillectomy, during two or three years in the surgical service of the Presbyterian Hospital. He says: "We have had ten or a dozen lung or brain abscesses following tonsillectomy. I think that this should be more generally known. Tonsillectomy is by no means a safe operation. It carries with it a very considerable amount of risk and the greatest risk is that of subsequent lung or brain abscess."

"The exact route of infection that occurs in these cases is not easy to establish in every case. There are certainly two possibilities, one that the infection occurs as a direct aspiration, pus and blood from the tonsils at operation being inspired into the thachea and bronchi and finding its way into the lung and there becoming a focus for lung abscess. I am inclined to believe that this is not the usual sequence of the abscess and that most of these lung abscesses following tonsillectomy are hematogenous, that the infection occurs at the site of the operation and obtain access to a vein, and is carried as a small infected embolus to the heart, and is admitted through the pulmonary arteries into the lung."

—————R—————

Up to the beginning of the nineteenth century most of the older scientists believed that the complete body, with all its parts, was contained in the ovum of animals, though too minute and transparent to be detected. The development consisted of the unfolding and growth of these parts. This was the so-called *pre-formative theory*. In logical sequence was also evolved the *theory of scatulation*. If the ovum contained the outline of the entire organism with all its parts, then the ovary of this embryo must also contain the ova of succeeding generations, and so

on. On this theory the great physiologist, Haller, calculated that "God had created together, 6000 years ago—on the sixth day of his creatorial labors—the germs of 200,000,000,000 men, and ingeniously packed them all in the ovary of our venerable mother Eve."

Liebnitz seems to have been fully in accord with this theory and attempted to harmonize it with his theory of the eternal and inseparable companionship of the soul and body and says: "The souls of men have existed in organized bodies in their ancestors from Adam downward—that is from the beginning of things."

—R—

Bevan says (Surg. Clin. Chicago, Oct., 1918): "In skin-grafting you should be familiar with the fact that autogenous grafts, that is grafts taken from the same individual, with good technic will almost invariably grow, that grafts taken from someone else almost never grow, for no matter how aseptically they are placed or how good the technic has been, at the end of ten or twenty days they usually break down and do little or no good. The fact should be widely known that in skin-grafting the graft must be taken from the same individual in order to have any prospect of success."

—R—

Galen first described the renewal of the blood in the lungs, but more than fifteen centuries elapsed before the element of the atmosphere which was taken into the blood was discovered by Lavoisier.

—R—

Excerpts—By The Prodigal.

THE MEDICAL SCHOOL

The December number of the Journal has more than a passing interest to the Prodigal, in this, that it gives the "Early History of the Medical School in Kansas," with papers from some of the teachers in the school.

Having been an actor in a small way before the footlights, in the practice of medicine and in the progress of medical education in Kansas, for almost a generation, he would be false to the trust once

confided in him by the medical profession for almost two decades, if he did not feel an interest in medical education, and in that of Kansas particularly.

The medical profession is in evidence more today than ever before in the history of the world. It merits this world wide confidence and respect, for the advance in medicine marks the progress of civilization. This is a period of progressive readjustment in human thinking and human action. The mode of travel has reduced this earth to a small sphere. The antipodes are our neighbors. State and national lines and boundaries are blotted out by the shibboleth of the fatherhood of God and the brotherhood of man. It cannot be said, in the spirit of the words of the lowly Nazarine, that we are not concerned with the causes and the objects of the war of any peoples or nations. The people of the United States, by their deeds, have proven to the world their altruism, their unselfishness, their philanthropy; and by putting this spirit to work have advanced civilization and made the world a bigger as well as a safer and better place to live in.

May I ask who were the principle leaders in this world movement? Who made it possible? Who was it that made the miasma breeding, disease incubating hot-beds and waste places of earth fit for man's abode? The questions are self answered. Mention only need be made of our own land. Witness Cuba and Panama. For generations Cuba was scourged with yellow fever, and our sea-bordering states on the Gulf of Mexico were terrorized by the dread of, and suffered from, Cuba's curse. Who has made Cuba a health resort for summer? Laborers, artisans, millionaires and statesmen and great nations tried to build the Panama canal, but failed. There are 2800 ties to every mile of railroad and the miasmatic diseases on the isthmus cost a human life for every tie. The French government abandoned the work. The medical man made Panama a safe and healthy place for human life and made possible the canal.

THE MEDICAL MAN

"He tells you what to eat and drink,
He tells you when to go and where,
And when to rest and when to think,
And when to act and when forbear.
You ask him where and how to build;
You ask him how to run your schools;
In every trade and every guild
As a good citizen the doctor rules."

and

"When others flee contagion's breath,
Forgetting Earth's most sacred ties,
And safety seek from march of death
'Mid healthier climes; 'neath cooler skies—
When others shrink from sight of woes,
And shut with horror from the gaze
The sight which only misery knows,
The state's best citizen, the doctor stays."

And all this has been brought about by knowledge, by education. Hence the vital necessity to educate the medical man. The people seeing the good that has been and is being done by the medical profession; the suffering it has relieved, the lives it has saved, the plagues destroyed, will be more than willing to support the cause of medical education. These evolutionary changes for the good of the human family have become accentuated and brought to public attention and appreciation during the present generation. Although a beacon light had appeared on the medical horizon at times, public sentiment had not measured up to the intelligence of the present generation to appreciate the good results.

It is said that public sentiment can do anything and, since there is an enlightened public sentiment sustaining the medical profession, and since state lines have been obliterated by the altruistic spirit for the good of the whole, we feel that Kansas is doubly blest in having a great university medical school to lead the way. Having lived in Kansas for forty years, the Prodigal is no doubting Thomas, but feels sure that the powers-that-be have seen the light and, sooner or later, will provide ample means to make the medical school a Mecca, not for medical students only, but for the physicians of Kansas and the middle west.

"This is a period of progressive readjustment in human thinking. We are getting rid of the personal fatalistic creation in the origin of things and now realize

that this is an orderly universe, always was—that nature's laws are always the same and unchangeable. That they are not changeable whimsical laws subject to change at human dictation or intercession."

Carrying a buckeye in your pocket will not ward off rheumatism, black cat's blood will not cure epilepsy or fits and toting a rabbit's foot will not insure success in life or good luck.

The physician must study the laws of nature (God's law) and get himself and his patient in right relation to his law—and that is the healing art that leads to success.

Emerson, or somebody, said that "life is the continuous adjustment of internal relations to external relations." This is a tip to the doctor to not disturb the adjustment.

It is claimed that eight men out of every hundred, but only two women out of every hundred are color blind. But, as uncle Chet Thomas used to say of Republicans in Kansas; "There's more on 'em." Twenty one boys are borne to every twenty girls.

Heat, light, magnetism, chemical affinity and motion can all be transformed into one another and are both manifestations of one and the same force. We are told that "certain indirect evidence, as that afforded by the periodic law and by spectrum analysis, has long lent strength to the view that the chemical elements (more than eighty of them) may be only very stable compounds of some simpler substance or substances. Recent radioactive discoveries seem to furnish direct evidence as to this; certain elements having apparently been observed in the process of disintegrating and being transformed into other elements."

Is this not a hint from nature's laws that the elements entering into the structure of the earth may be found to be one substance? Nature's simplicity so far proves to be man's complexity.

BOOKS.

The Surgical Clinics of Chicago.

The Surgical Clinics of Chicago, Volume II. Number 5 (October, 1918. Octavo of 193 pages, 87 illustrations. Philadelphia and London: W. B. Saunders Company. 1918. Published bi-monthly. Price, per year: Paper, \$10; cloth, \$14.

The Surgical Clinics for October contains some very interesting reports. Bevan presents a series of surgical cases that are not only interesting but are of great practical value. Eisendrath's clinical lecture on "The Acute Abdomen" is well in advance of the general thought on this subject. The very excellent illustrations add clearness and emphasis to the facts he points out. McKenna's clinic on "Genito-Urinary Surgery" is also of exceptional practical value. There are also articles by Mix, Printy, Moorhead, Watkins, Reed, Parker, Bernstein and Ochsner.

Surgical Treatment.

A practical treatise on the therapy of surgical diseases for the use of practitioners and students of surgery. By James Peter Warbasse, M.D., formerly attending surgeon to the Methodist Episcopal Hospital, Brooklyn, New York. In three large octavo volumes, and separate desk index volume. Volume II contains 829 pages with 761 illustrations. Philadelphia and London: W. B. Saunders Company. 1918. Per set (three volumes and the index volume): Cloth, \$30.00.

The second volume of Warbasse fully justifies the expectations aroused by the first volume. It is no small undertaking to collect and arrange the subject matter required to cover the whole field of surgery, but to condense it without detracting from its instructive value,, to eliminate the unimportant and give proper emphasis to the most important, requires not only a literary genius but one who is also well grounded in surgery, with large experience.

The first 320 pages of the second volume is devoted to the treatment of injuries and diseases of the head. Then follows the neck, the thorax, the breast; and then the last 290 pages are devoted to the surgery of the abdomen.

Dispensaries, Their Management and Development.

A book for administrators, public health workers and all interested in better medical service for the people, by Michael M. Davis, Jr., Ph.D., director of the Boston Dispensary, and Andrew R. Warner, M.D., superintendent of Lakeside Hospital, Cleveland. Published by the Macmillan Company, New York. Price, \$2.25.

This is a review of the history of dispensaries, followed by suggestions as to the proper equipment, organization and daily conduct of dispensaries. The book

also aims to present the dispensary as a form of organization for rendering efficient medical service to the people. "The dispensary has generally been regarded as a form of charity. To a large extent existing dispensaries are that; and worthily so. But the trend of medical science, and the necessary implications which follow for medical service, create a demand for the practice of medicine through organized rather than through an individualistic system such as has prevailed in the past."

Home Nursing.

A text-book of home nursing; modern scientific methods for the care of the sick. By Eveleen Harrison. Second edition, revised. Published by the Macmillan Company, New York. Price, \$1.10.

This is a very excellent little book which well fulfils the purpose for which it was written. Very simple but very definite directions are given for the home care of the sick, beginning with the preparation of the room and bed, and continuing with directions for taking the pulse, temperature and respirations, giving baths, preparing and giving medicines and food, and a great many other valuable directions and suggestions which people generally ought to know.

— R —

A Request.

Editor Journal:—

Will you kindly call attention in the next issue of your journal to the fact that Dr. Francis D. Patterson, Chief, Division of Industrial Hygiene and Engineering, Department of Labor and Industry Harrisburg, Pa., is desirous of obtaining a complete list of all physicians engaged in the practice of industrial medicine?

It has been the practice of this Department to hold semiannual Conferences of Industrial Physicians and Surgeons for several years. These Conferences are well attended, and a great deal of valuable matter is presented in the discussions. In order to reach all physicians interested it is desirable to have their names upon our mailing list. The next Conference will be held early in 1919, and it is, therefore, essential that the names and addresses of all Industrial Physicians and Surgeons be in my hands as soon as possible after January 1st.

Expressing to you my deep appreciation for your courtesy in calling this matter to the attention of your readers, I am

Very sincerely yours,

FRANCIS D. PATTERSON

Chief, Division of Hygiene.

SOCIETY NOTES.

BOURBON COUNTY MEDICAL SOCIETY

The Bourbon County Medical Society met in regular session at the Library Building, Fort Scott, December 19th, 1918 at 6:30 p.m. with the following members present: R. Aikman, Fort Scott; E. E. Anderson, Garland; J. J. Cavanaugh, Fort Scott; J. S. Cummings, Bronson; W. S. Gooch, Mapleton; L. W. Griffin, Fort Scott; W. L. Hopper, Fort Scott; J. D. Hunter, Fort Scott; M. F. Jarrett, Fort Scott; W. S. McDonald, Fort Scott; J. R. Newman, Fort Scott; E. B. Payne, Fort Scott; C. A. Van Velzer, Fort Scott; R. J. Whitfield, Fort Scott; C. F. Young, Fort Scott; Visitor, J. A. Naylor, Fort Scott, but a member of the Linn County Society.

The meeting was called to order by J. R. Newman, President. The minutes of the previous meeting were read and approved.

The petition of Drs. C. F. Harrar, Fort Scott, and E. D. Tanquary, Bronson, were voted on and both men declared elected to membership in the Society.

By a unanimous vote it was agreed the Society should contribute a page in the Fort Scott Tribune as Red Cross advertising. The cost of this to be Thirty Dollars.

An application for reinstatement of Dr. A. H. Adamson, Arcadia, Kansas, was received and voted upon favorably.

Election of officers for the ensuing year was next taken up and all of the present officers were re-elected. The names of whom are as follows: J. R. Newman, Pres. J. S. Cummings, Vice Pres., W. S. McDonald, Treas., C. F. Young, Secy.

Dr. M. F. Jarrett, being elected a year ago to serve as delegate to the State Society for two years, the election of this officer was not necessary.

The term of Dr. R. Aikman, Censor, expiring at this time he was re-elected for three years.

Censors are as follows: J. C. Lardner, Term expires Dec. 1919, 1 year; J. D. Hunter, term expires Dec. 1920, 2 years; R. Aikman, term expires Dec. 1921, 3 years.

Dr. W. G. McDonald, Treas. submitted a report of the Treasurer for the past three years, with income and disbursements. The books now showing a balance of \$33.50. The report was accepted and ordered filed with the Secretary.

There being no further business, the

meeting adjourned to the house of Dr. J. R. Newman, 510 south Eddy Street, where an elegant dinner had been prepared by Mrs. Newman, for the members of the Society.

All members present at the meeting attended the sumptuous dinner of five courses given by Dr. and Mrs. Newman, and those not filled to the teeth have no one to blame but themselves, as there was an abundance of well prepared and delicious food. In addition to the many good things to eat. Conines Orchestra of four pieces rendered splendid music throughout the dinner.

After all stomachs had been filled to full capacity, the members retired to the guest room and listened to several funny, though splendid recitations by Mrs. Ruth Wright Lampton.

Several comical records were rendered on the Victrola which afforded many hearty laughs to the Physicians.

Following this, Drs. Newman and Payne gave very interesting accounts of their trip to the East, where they visited the Johns Hopkins Hospital and the Radium Institute of Baltimore, Md. A day at Dr. Jno. B. Deaver's clinic, Philadelphia, Pa. The Radium Institute, Pittsburg, Pa., and on their return the Clinics of Dr. A. J. Ochsner, Chicago.

The above talks were very interesting as well as instructive.

There was quite a little discussion on the "Flu" epidemic, engaged in by most all present, though no one seemed to purport to know a lot about the "Flu", excepting all agreed it was the "dickens."

The hour being late, a motion was made, seconded and carried, to vote Mrs. Newman a rising vote of thanks for the splendid dinner, and the lovely evening spent at her home.

STAFFORD COUNTY SOCIETY

The Stafford County Medical Society met in St. John, Wednesday, Dec. 11th, with the following members present: H. H. Miner, M. M. Hart, W. C. Bundrant, J. T. Scott, F. W. Tretbar, L. E. Mock.

The annual address was read by the President, Dr. H. H. Miner after which the following officers were elected for the ensuing year: H. H. Miner, Macksville, President, re-elected; C. S. Adams, V. Pres., St. John; J. T. Scott, St. John, Sec-Treas.

On motion the society authorized subscription to the "Increased Efficiency in

Diagnosis Case Records" for 1919, published by the Massachusetts General Hospital. It is the purpose of the Society to use this weekly publication as a regular program for their monthly meetings.

Society adjourned to meet in Stafford the second Wednesday in January at 3 p.m.

J. P. Scott, Sec.

***ADDRESS.**

On behalf of my co-workers herein assembled, I wish to welcome you to the annual gathering of our official family and their associates.

Every truth started on its way by this body of men, though its purpose may seem to have been accomplished, is still going on and on and divided though it may be in its journeyings, is indestructible, and today is serving some good end. Certain it is that no one familiar with our labors will attempt to deny that our society is an inspiration to many and the example set by true hearted medical men has its effect upon many without as well as within our circle.

The year just passed marks another period and closes another chapter in history. You gentlemen, though beset on all sides by everything which could discourage man, have bravely kept your faces to the front, have secluded your worries, have encouraged those dependent upon you for advice, have given your support to every cause advanced, have accomplished that which you set out to do with that feeling of satisfaction, which comes to man from good work performed, and now join at this time to take counsel of one another for future guidance.

It means the unification of hearts, which beat in common for a single purpose, it establishes a concentrated working basis for the future, it typifies good will and brotherly love.

We are all friends and by friends I mean the truest union of minds of which men are capable; actions not words, are the true criteria of all attachment of friends, and by actions we know our best friends.

This organization should be one of fraternity and harmony, the strongest army of its kind in the world. We ought to thank God every morning when we get up that we have something to do that day which must be done whether we like it or not. Being forced to work and do our best will breed in us virtues the idle never know.

A teacher is not one who imparts the

most facts always, but one who inspires, by supplying a noble ideal. Let the organization of which we are a part, strive toward an ideal of greater friendliness among ourselves, honest opinions, kindly help, for we are human and liable to mistakes. Then the organization will be benefitted by our deliberations, I am sure, and we will be drawn a little closer together by the gathering, I am certain.

The world is what we make it and we intend to go forward, forward in keeping faith, forward in truth, forward in friendship, so that when we are called together a year from now, our society will be stronger and present a record worth while.

Thanking you for your kind attention and extending to all the seasons greetings, will close with these words, harmony, fraternity and organization, let them be the magic watchwords of our society.

*Annual address delivered by Dr. H. H. Miner, Macks-ville, Kansas, to the members of the Stafford County Medical Society.

SUMNER COUNTY SOCIETY.

The Sumner County Medical Society commenced its fifteenth year by electing the following officers for 1919: M. W. Axtell, Argonia, president; Capt. W. M. Martin, Wellington, vice-president; T. H. Jamieson, Wellington, secretary-treasurer; T. J. Hollingsworth, South Haven, censor; Capt. F. F. Netherton, Wellington, delegate.

Alfred Hultner, Belle Plaine, and J. R. Burnett, Caldwell, were elected to membership. T. H. JAMIESON, Secretary.

FRANKLIN COUNTY SOCIETY.

On account of the epidemic of influenza the Franklin County Medical Society has not held a meeting since September 30.

Dr. F. C. Herr, county physician, has been confined to his home with influenza for two weeks. Dr. Wm. Michener has recently received an honorable discharge from the M.R.C. and has returned to Ottawa to resume the practice of medicine. Dr. G. W. Davis, who had recently made preparations to go to France in the interests of the Red Cross, and had received the needed official papers, was prevented from doing so by the signing of the armistice.

H. L. KENNEDY, Secretary.

—B—

Yeast in the Treatment of Constipation.

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and other physicians (see article by them in Jr. A. M. A. vol. LXIX; No. 15; Oct. 13, 1917, pp. 1243-1247). In fact in ten cases of constipation in which they used yeast, nine were improved or cured. The tenth case was associated with high intestinal stasis and subacute appendicitis, so that this was hardly a fair case in which to expect a curative action of yeast. In one case the movements became so free that it was necessary to discontinue the use of the therapeutic agent. The cases of constipation varied in duration from a few weeks to several years. Fleischmann's Compressed Yeast was the agent employed. One-half to one cake of yeast, was administered about three times a day, usually before meals. In many cases the bowel movements became regular after only a few days of treatment, sometimes immediately.

The use of yeast in the treatment of constipation was by no means new when Hawk and his co-workers undertook their researches on its action. Gunzberg (Munchener med. Wochenschrift; July 7, 1896, pp. 631-632), recommended small doses of bakers yeast in the treatment of enteroptosis, stating that one of its good effects was that it enabled the victims of the disease to take on the necessary fat. Aaron (Diseases of the Digestive Organs, etc., 1st edition 1915; 2nd edition 1918) in his chapter on constipation, writes thus about the treatment of atonic constipation:—"Good results are reported from yeast taken once or twice a day, according to the number of bowel movements caused."

The full action of yeast on the gastrointestinal tract is well worth determining. According to Hawk and his co-workers, there is associated with all actions of yeast a general improvement of the patient's general condition. With this accords the statement of Gunzburg mentioned above that the patient takes on fat. It is possible that the general increase in well-being may be associated with an increase in general tone, which in turn may affect peristalsis favorably, and bring about a daily evacuation, as a permanent condition. It is noteworthy in this connection that the chief use of yeast has been in connection with cases of atonic constipation. It, however, does not seem to be contraindicated in the spastic constipation of enteroptosis (see reference to Gunzburg above) which according to Gunzburg needs oil enemata for its relief.



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(3004)

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The Relation of Focal Infection and Protein Poisoning to the Upper Respiratory Tract.

J. E. SAWTELL, M.D., F.A.C.S., Kansas
City, Kansas.

Read at the Annual Meeting of the Kansas Medical Society
held at Kansas City, Kansas, May 1, 2 and 3, 1918.

The above subject in its various aspects is too vast to be considered in the brief time allotted to this paper. The handling of such a subject in a comprehensive manner should be the result of the combined efforts of a physiologist, a pathologist, a chemist, a neurologist, an internist and a rhinologist. To this end I have sought to avail myself of the most helpful information obtainable and have endeavored to give due credit for the same.

Many of the nasal disturbances have long been a bewilderment to the rhinologist on account of our ignorance of the anatomical, physiological and pathological conditions concerned in their productions.

In order to understand how protein toxins affect the upper respiratory apparatus, a knowledge of the nerve mechanism involved is essential.

According to Fetterolf the vegetative system of nerves supplies all glands that have ducts and all involuntary muscle tissue, and is divided into two distinct parts—the autonomic and the sympathetic. The place of origin of the vegetative fibers is in the brain and spinal cord. The fibers which comprise the autonomic portion, with which we are most concerned, are contained in the third, seventh, ninth, tenth and eleventh cranial nerves.

The autonomic fibers of the seventh

nerve with those from the ninth, tenth and eleventh go to various ganglia and finally innervate the blood vessels of the mucous membrane of the mouth, throat, nose, paranasal sinuses and salivary glands. In action the two groups, the automatic and the sympathetic, are antagonistic, hence it is said that "upon the maintenance of a proper balance between the two depends the normal functioning of the structure to which they go." If the autonomic supply receives a stimulation the result will be overfunctionation in one direction, that is, vagatonia or hypertonus of the above mentioned group of nerves. If the sympathetic is in a state of hypertonus, the excessive action will be in the other direction.

In vagatonia, then, we have hypersecretion and spasm, while in hypertonus of the sympathetic supply we have a hyposecretion and relaxation. The extreme symptoms of vagatonia in general are those expressed in anaphylactic shock. The nerve cells of the two groups—vasodilator and vasoconstrictor—may be excited or inhibited by nerve impulses transmitted from the nasal chambers by the nasal and other branches of the trigeminal nerve and from the skin by the cutaneous nerves, or by impulses descending from the cerebrum in consequence of psychic states of an emotional character.

It is evident from clinical phenomena, supported by pathological conditions, that the tonus of one or more of these centers may be abnormally increased or decreased by changes in their nutrition caused by toxic products of metabolism. It is the conclusion of all who have made investi-

gation that the toxic element is a protein substance.

There are certain fundamental principles of protein poison manifestations generally recognized:

First—That all food stuffs contain a protein poison that can be extracted and isolated.

Second—By long continued excess of protein intake, especially of a limited variety, the apparatus of metabolism becomes impaired so that it cannot handle the protein physiologically without undue reaction from the poisonous elements it contains.

Third—Through the inability to properly metabolize proteins, abnormal reaction may be produced in tissues or organs of the body. Such reactions are protein poison manifestations.

A protein poisoning may be the result of focal infection. By autolysis of the dead micro-organisms of the focus the bacterial proteins are set free and thus gain entrance to the blood stream parenterally when the same abnormal reactions are produced as those by the food proteins.

Vaughn says: "Just as the protein in the body of the bacillus is the poisonous element and the cause of abnormal reaction in infectious disease, so the protein poison in food stuff is the true basis of disease not due to infection."

When a foreign protein gains entrance to the body, enterally or parenterally, the animal body always responds to the introduction of the foreign protein by the production of specific antibodies after a certain period of time. According to Cooke, the specific antibody exists either attached to certain cells or free. When union takes place between protein and free antibody there is no clinical evidence of a reaction, but when union takes place between protein and fixed antibody a reaction takes place. When there is a large excess of antibody circulating free we have an immune state, and when there is little antibody and that for the most part attached, we have the sensitized state.

This may be an explanation of the rea-

son why in one instance an individual may have the typical phenomena of anaphylactic shock, and at another time or in another individual it may be a manifestation of some form of the so-called "nasal neurones," or it may be a bronchial asthma, some dermatological lesion, gastro-intestinal symptoms, cardiovascular disturbance or some other morbid condition.

The clinical phenomena of protein poisoning, so far as they relate to the upper respiratory apparatus, are all the symptoms of an inflammatory process except the local reactions that are produced by pathogenic bacteria.

This is best illustrated by the symptoms of pollenosis. When the protein substance contained in the pollen gains entrance to the body and forms a union with the fixed antibody, nerve impulses are discharged which are transmitted by the afferent nerve mechanism, found in the branches of the trigeminal nerve, to the sensory nerve cells of the cerebral cortex. These impulses are discharged by the central cells and are transmitted by the autonomic nerve supply which in turn discharge impulses that are distributed in a spray-like manner to the glands and muscular walls of the arterioles. It contains both secretomotor and vasodilator fibers. As a result there is a dilatation of the capillaries supplying the large number of thin-walled blood sinuses found in the delicate submucous connective tissue which compose the erectile tissue of the turbinated bodies. At the same time there is a hypersecretion of the numerous mucous glands, the ducts of which open at various points on the mucous surfaces. As a consequence there is an engorgement of the blood sinuses causing a blocking up of the nasal passages, more or less, with an attendant hypersecretion of mucous and serous fluid. These are the clinical phenomena of an exaggerated type of protein poisoning affecting the nasal apparatus. In other words, it manifests the symptoms of an inflammatory process minus the local morbid anatomy produced by the pathogenic bacteria and the resultant constitutional

disturbances which may vary according to the virulency of the micro-organisms.

The vascular and glandular supply about the pharynx may exhibit the manifestations of a protein poisoning, in which case there is hypersecretion just as in pollonosis affecting the intranasal structures. Inspection reveals nothing but an engorgement of the venous supply over the base of the tongue and the lateral walls of the pharynx, and a flooding of mucous and serous secretions.

A patient, male, aged 58, otherwise in good health, presented himself suffering from symptoms as above described. So excessive were the secretions that rest was impossible during day and night. On making inquiry as to his diet it was found that for a long time he had been subsisting largely upon potatoes. A change in his diet brought immediate relief. I have had him under observation for about five years and during this time he has made many attempts to return to a potato diet, but always with a return of the symptoms which disappear again with a change of diet. This is a type of food protein sensitization as it affects the pharynx.

On account of the richness of the blood and glandular supply and the complex nerve mechanism, the turbinal tissues of the nose are probably the most responsive to protein toxin effects of any tissues in the human body. More reliable, however, as an index of this condition, is the inferior turbinal, as it is seldom the site of a chronic focal infection. This structure therefore furnishes a most interesting and valuable field for the study and investigation of the clinical effects of protein poisoning, regardless of the source of entrance. It makes no difference whether it is a food or bacterial protein the reaction is the same, varying in degree according to the intensity of sensitization, the amount of the foreign protein and the rapidity of its introduction. A certain degree of tolerance may be established. This may be observed in a patient suffering from multiple foci of infection when some have been removed. For example: A

patient may be suffering from an infected gall bladder and diseased tonsils at the same time when the nasal tissues will show a turgescence. A removal of either focus and the nasal tissues will usually return to the normal for a certain period of time, but unless the other focus is removed they will again return to the former turgescence state. A removal of the second focus and the nasal index will again become negative and remain so if there are no other portals through which a foreign protein is gaining entrance.

It is frequently the case that both the teeth and the tonsils are the sources of chronic infection. Should such a patient be suffering from toxic symptoms, rheumatic in character, and without any secondary anatomical lesions, the removal of either source of infection will usually afford immunity from the symptoms for an indefinite time, depending much upon hygienic and climatic conditions. If the tonsils are removed first the nasal index will usually become negative and remain so during the period of tolerance unless the dental infection is extensive. Should the dental infection be removed first, the nasal index will likely remain positive for the reason that toxic material gains entrance to the body more rapidly through the tonsils than from infected teeth.

A chronic focal infection in any part of the body may register its effect upon the sensitive nasal tissues. Without any other therapeutic measure I have seen the nasal index change from positive to negative by the drainage of an infected gall bladder, the removal of a diseased appendix, the correction of the paranasal sinus disease, the relief of gastrointestinal and genitourinary disturbances as well as the removal of infected tonsils and teeth.

The intranasal symptoms of protein poisoning, usually described as simple chronic rhinitis, chronic rhinitis, turgescence rhinitis, etc., are not the part of a local inflammatory process but merely the reflections of a protein poisoning.

A focal infection that is confined seems to produce the highest degree of sensitiza-

tion. On this account the tonsils, teeth and ethmoid labyrinth are the sources from which a bacterial protein sensitization may frequently occur. In one instance it may be buried tonsils, while in another the lacuna may be sealed up from inflammatory action or by the plica. However, the most serious consequences result from an incomplete enucleation. The smallest portion left is more dangerous than a large amount, as it is more easily covered over with cicatricial tissue. In teeth involvement it is not the open alveolar abscess but the infected root canal or pulp, of which the patient may have no warning, that produces the most pronounced sensitization.

The ethmoid labyrinth, on account of its delicate and intricate anatomical structure, may easily become a focal center of infection and the cause of sensitization. Bronchial asthma has long been associated with ethmoid disease. Long before there was any knowledge of focal infection and sensitization it was known that the removal of polypi afforded some relief. The hope of a complete and permanent cure finally led to the total exenteration of the ethmoid labyrinth with the following results:

When the ethmoid is the only source of sensitization, a cure is effected. If there are multiple sensitizations and the ethmoid is one, either an amelioration of the symptoms or a complete temporary cessation is the result. On account of the tolerance established, the patient may remain without symptoms for months or years, until from lowered resistance or from some other cause there is an increase in the amount of systemic protein intake, then tolerance ceases and asthmatic symptoms return.

According to Cooke, more than 50 per cent of his cases that were sensitized at all showed multiple sensitization. Duke, in his work on "Oral Sepsis in its Relationship to Systemic Disease," states: In the examination of one thousand medical cases on account of miscellaneous systemic complaints, 72 per cent of those

having a considerable degree of oral sepsis had other chronic infections. In but 18 per cent was oral sepsis the only active infection found.

As previously stated it is the confined focal infection that seems to bear the greatest relation to sensitization, but it seems reasonable to presume that when sensitization to a foreign protein has been established and then reduced to a state of tolerance, many of the miscellaneous infections, both acute and chronic, could be the means of re-establishing the sensitized state. Clinical observations seem to warrant the assumption. That food protein poisoning can produce a sensitized state in some degree seems now to be well established, but that it can be an integral factor in the production of bronchial asthma is not universally supported. But that it does act in conjunction with a sensitized state due to bacterial protein poisoning and that it may be the means of changing a tolerant to an intolerant state, is well supported by clinical observations.

From an analysis of the above it is not difficult to reason why intranasal surgery has not done more for the cure of bronchial asthma.

SUMMARY.

(1) The tissues of the inferior turbinate furnish a most valuable index for study of the clinical symptoms of protein poisoning.

(2) The so-called "simple chronic or turgescient rhinitis" is not an inflammatory process, but the manifestation of a protein poisoning.

(3) A focal infection producing sensitization rarely gives a history of acute local reaction.

(4) Chronic focal infections with recurrent acute local reactions do not of themselves produce symptoms of the sensitized type, but the more direct toxic effect.

(5) Many infections, miscellaneous in character, both acute and chronic, may be the means of bringing about resensitization when tolerance to a sensitizing focus has been established.

(6) Extravagant claims for the cure of

bronchial asthma, by intranasal surgery alone, are unsupported by scientific investigation and careful clinical observation.

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—R—

Annual Registration in Medicine.

C. F. NELSON, M.D., Ph.D.

University of Kansas, Lawrence

We are living in a recording age. The state and nation, the church and lodge, manufacturers, merchants and scores of other individuals and organizations are continually putting us on innumerable lists. In a hundred ways we are "marked" men. The slang phrase, "get his number," tells the whole story simply and well. We are all registered, labeled and numbered on the slightest pretext and for the most trivial reasons. Somebody is always "getting someone's number." Its the phobia of the day.

To be sure, modern life is extremely complex and the extent to which the world's labor is subdivided has become so great that a considerable amount of registering is necessary. There is no objection to a certain amount of it, but where shall the process stop? Granting that a little is good and necessary, does it follow that still more is desirable and beneficial? Sooner or later this question must be definitely settled and its determination so far as Medicine is concerned is at the present time before us.

It is now proposed to register physicians annually. So far, at least, medicine has escaped this ordeal of efficiency. A single registration with a state board, after taking proper examinations, together with subsequent registration with the clerk in the county where practice is to be established, has been considered sufficient. Arguments are now being advanced, however, that life registration is inadequate. We are told that under the old system the whereabouts of physicians cannot be ascertained accurately. No central authority knows where they are, or what they are doing. Quacks and fakers of all sorts infest the profession and practice without licenses because annual lists are not available. Men who have no right to practice obtain licenses of dead men and use them as though they were their own. Annual registration, together with an annual fee insignificant in amount, is all that is necessary to "clean house" and preserve order ever after.

Examined superficially these arguments look plausible, inviting and convincing. Who would not for \$1.50 or \$2.00 a year have a clean profession and, incidentally, serve the public by eliminating the unfit? It is worth twice the amount of money. Furthermore, we need no longer concern ourselves with the matter of reform. The job will be definitely assigned to others, the contract let and we may proceed to forget all about it. The governor of the state, or possibly civil service machinery, will select the men needed. All for the small sum of your name and address once a year plus, say, a financial consideration of two dollars—probably not one-twentieth of what you annually pay for lodge dues.

Many physicians will undoubtedly decide in favor of adopting such a plan on the general proposition that it looks reasonable, is certainly cheap and worth while trying. Others will have in mind some misuse of the medical practice act in their own community and welcome the plan as a good and easy means of putting the pincers on particular offenders. Still others will argue that the public needs protection

from charlatans and quacks and they are willing to pay someone to have this done. The method proposed seems a very happy and efficient one and should, therefore, be tried.

A score of plausible arguments in favor of a plan of this sort may, indeed, be deduced, all of which seem eminently reasonable so long as attention is fixed on but one side of the question. These arguments, however, assume entirely different proportions when viewed from standpoints even more vital to the profession and to the state. While undoubtedly a state board, armed with the considerable budget which even small fees will bring in, would be able to do some good, both to the profession and to the public at large, the price physicians would have to pay for these reforms along lines far more significant and important to them would be tremendous. Better ways might easily be found to accomplish the same ends without compromising the whole professional status of Medicine, as annual registration inevitably will do.

There are many reasons why annual registration and collection of fees will compromise the professional status of Medicine. We must not forget that in order to make collection practicable a penalty will have to be imposed for non-payment of fees. This penalty may, for example, take the form now enforced by the Illinois Department of Registration and Education in the Care of Registered Pharmacists:

**"If you are actively engaged in the practice of your profession, the fee is \$1.50 if paid between January 1 and March 1, 1919; if paid between March 1 and April 1, 1919, it is \$3.00; and if paid between April 1 and May 1, 1919, it is \$5.00. If it is not paid before May 1, 1919, your certificate will become null and void and the only way you can become reinstated as a registered pharmacist is by filing a formal application and passing an examination."*

Can the profession afford to put such a

powerful lever into the hands of any board or body of men?

Will not the inevitable tendency be to inaugurate a "year at a time" type of professionalism, stripped of all continuity, and incidentally of the respect that comes with permanence of title? No profession can exist under such precarious conditions. Good standing in medicine must ever consist in doing honest work and in giving genuine professional service, not in keeping paid up with a state board. Fitness, years of service, professional prestige, count for nothing, once a plan of annual registration and fee collecting is inaugurated. It all becomes a matter of book-keeping. If you lapse in your dues, your professional status ceases. No possible reforms could be great enough to offset the damage resulting from such a move.

A young man spends seven years to become a physician. He passes the state board examinations and is admitted to practice. The license then given him indicates a contractual relationship on the part of the state permitting him to practice his calling during good behavior or for a lifetime. Can there be any possible reason why his refusal to enroll and to pay a fee annually, even granting that the registration and fee will be beneficial to the profession and the people, should operate as a penalty so severe as a revocation of a license? From the point of view of the profession, the sentiment and just pride which its members now take in belonging to the calling will be gradually lost and supplanted by a purely business motive; from the point of view of the individual, the thing that he has justly earned by many years of hard work will be all too easily taken from him. No possible advantages to be gained would equal those lost.

The argument that charlatans and quacks infest the profession and prey on the public, particularly in our large cities, is undoubtedly only too true. But annual registration and annual fees are no panacea for such evils and, even granting that they were, it seems doubtful whether

some other course should not be adopted in dealing with this problem. States—at least American states—do not make laws penalizing or even inconveniencing respectable and law-abiding men in order to apprehend those that violate their statutes. The police, even in our large cities, never think of registering honest people in order to catch thieves. It would be far handier for them to have a list of all citizens—a registration bureau where they could be checked up and their whereabouts ascertained every so often. Crime could undoubtedly be reduced, but the price would be a type of bureaucracy which independent people will not tolerate. If annual registration and fee collection is *enforced* in Medicine, a condition precisely similar will obtain. The plan is undemocratic and unnecessary. The evils which it promises to cure should be and can be met in other ways more in harmony with American ways of doing things.

In arguing against annual registration and fee collection there is no desire to minimize the evils which exist or to infer that something should not be done to correct them. There should be concerted effort on the part of physicians to obtain from the state legislatures appropriations sufficient to maintain proper inspection of licenses and enforcement of all laws pertaining to the practice of medicine. This may, as has been suggested, best be done by men outside of the profession. To compel the members of a profession to pay annual dues for the enforcement of laws which the state has made in the interests of the people is decidedly unfair. Most physicians could easily be induced to let the state board know where they are, annually or semi-annually, if it were really necessary. But to adopt a plan which would force such action at the price of possible professional disfranchisement would mean the giving over of the very life of the profession to an outside agency whose benevolence alone would determine its future growth and successful development.

*Annual letter sent out to registered pharmacists for renewal of certificates.

"Quinine Q.S."

F. A. CARMICHAEL, M.D., Osawatomie, Kansas.

The purpose of presenting for your consideration the subject of quinine as a therapeutic agent is prompted by the fact that perhaps no single drug is more universally used than this. It is self-prescribed, counter prescribed, prescribed by the physicians as well as by the friends of all classes of people for all classes of ailments. The position taken by the writer is that the therapeutic virtues for the various number of ailments that are ascribed to quinine are absolutely unfounded; that nothing in the physiologic action of this drug aside from its specific effect upon the malarial parasite and certain uterine troubles is warranted by our present knowledge of its therapeutic action. And on the contrary that the harmful effects of quinine are perhaps as little understood by the average practicing physician as by the laity. A brief resume of the history of this drug so far as we may go is of historical interest only. It is commonly known that it receives its name in honor of the Countess of Cinchon, who was cured of tertian malarial fever by its use in the seventeenth century; that because of religious bigotry it was suppressed from general distribution for nearly fifty years, and was finally introduced about the middle of the seventeenth century by the Jesuits of Rome, who approved of the distribution of a certain amount of this bark applied to those afflicted with malarial disease in the great Roman Campania. It is also of interest to note that its introduction to England was through the agency of a quack.

The first crude discovery of the active principles of cinchona were established by Duncan in 1703, but were not perfected by Pelletier and Caventon until 1820. In support of the contention raised, attention is called to a consideration of the physiological action of this drug. Externally and locally it is an antiseptic preventing the growth of infusoria and arresting putrefactive fermentation. Upon the

abraded skin surface it is a decided irritant, also upon the mucous membranes. Internally in full physiologic doses its action upon the gastric mucosa exhibits the same intensely irritating quality. In minimum doses it acts as the simple vegetable bitters, augmenting both salivary and gastric secretion, the latter in the form of hydrochloric acid, which is increased under its use.

Upon the circulatory system minimum doses increases the force and frequency of the heart's action, while excessive doses slow and weaken, a condition that is so frequently overlooked that the marked intermittency of the pulse in children to whom quinine is administered is often looked upon in alarm by the attendant, and increased instead of decreased doses of the drug given.

Its action upon the blood is distinctly hemolytic. It not only causes disintegration with destruction of hemoglobin in the red cells, but it arrests the amœboid movement of the polymorphonuclear leukocytes, inhibiting their migration through the capillary walls and likewise diminishing their numbers, resulting in leukopenia. It retards and impairs all the oxidizing power of the body and materially lessens the oxygen-carrying capacity of the red corpuscles. Bodily metabolism is impaired.

It is said with reference to its action upon the nervous system that small doses stimulate the cerebrum. This statement is emphatically denied by modern writers. Large doses occasion cerebral congestion with sensations of dizziness, fullness in the head, tinnitus and other symptoms classified and described at length under the title of Cinchonism. The reflex function of the spinal cord is reduced and by toxic doses ultimately abolished, primarily due to overstimulation of Setschenow's inhibitory center and latterly due to direct depression of the spinal cord and nerves.

Upon the respiratory system it is recognized as having but very slight effect, minimum doses being said to stimulate respiration, while the ordinary therapeutic dose depresses and diminishes the respira-

tory movements both in number and amplitude, and in toxic cases death almost invariably results from respiratory paralysis. The excretion of uric acid, urea and other nitrogenous material is considerably diminished under its use. Its effect upon the temperature in health is nil. In febrile conditions, aside from those of malarial and puerperal origin, its effect is questionable, and it cannot be classified as a true antipyretic, as it has not at any time been shown that it exerts any influence upon the heat-controlling centers.

Its effect upon the eye is infrequently that of transient amblyopia or amaurosis, and the occurrence of these as chronicled in medical literature are by no means infrequent, permanent blindness resulting from the over-administration of quinine in practically the same degree of frequency as from the administration of wood alcohol.

Referring to the gradual disuse of quinine as a therapeutic agent we have but to refer to the standard therapeutics of twenty years ago in comparison with those of today. Fowler in his *Practical Therapeutics*, Volume 2, 1896, gives the following cases in which quinine is said to be used with highly beneficial results: In obstetrical and gynecological cases as an abortifacient, emmenagog, uterine stimulant, as a specific for malaria, as an antipyretic, analgesic and antiseptic in typhoid and typhus fevers, as almost a specific in acute articular rheumatism, as of particular value in puerperal fever, as a splendid remedy in small pox and scarlet fever, to be used both internally and locally in diphtheria, as the principle remedy in cholera, as regarded by many a specific in pneumonia, as antipyretic in tonsillitis, as a prophylactic, pertussis, as of value in the hectic fever of phthisis, as a valuable agent in chronic phthisis, chronic bronchitis, asthma, coryza, hay fever, influenza, insolation, headache, migraine, leukæmia, diabetes, pityriasis, urethral fever, gonorrhea, cystitis, growths at the neck of the bladder, amœbic dysentery, locomotor ataxia, Meniere's disease, sciatica, hydrops

articularum, hematuria, stomatitis, empyema, pruritus, glaucoma, Neisserian ophthalmia, chorea, nocturnal enuresis, making forty-five diseases in which the administration of quinine is especially recommended.

In the review of Butler's text on Therapeutics, accepted as a current text book and published in 1904, we find the scope of diseases narrowed to sixteen. These comprise malaria, hay fever, ozena, whooping cough, neuralgia, headache, jaundice, asthma, diarrhea, dysentery, septicemia, puerperal fever, endocarditis and pleurisy, showing a diminution of two-thirds in the therapeutic applicability of this drug within a period of ten years. Since 1904 the therapeutic scope of quinine has gradually decreased. A more thorough understanding of its physiologic action, of its various abuses, of the danger of its administration, of the questionable therapeutic results obtained from it in a majority of cases, of its possible injurious effects upon the reflex nervous system, its heart-depressive action, its tendency to produce cerebral engorgement and frequent untoward clinical manifestations in the form of various degrees of cinchonism and the by no means infrequent occurrence of permanent blindness and deafness as a result of its use have tended to curtail in a great measure its employment by the modern physician in the broadcast and indiscriminate manner of his predecessors.

For over 200 years quinine has been administered by the profession more frequently without the hope or expectation of obtaining therapeutic results than because in the mind of the profession it exhibited nothing harmful in its administration aside from certain unpleasant symptoms that in themselves were deemed of psychic value to the patient. Very few drugs receive more scant attention so far as their physiological effect is concerned than this.

The spirit of empiricism, like Banquo's ghost, will not down in the medical profession, but rears its head again and again when we are least expecting it, seductively

beckoning us to follow in the footsteps of our predecessors. For instance the following quotation derived from Basil in 1704 will give some idea of the conceptions of the therapeutic virtues of quinine at that time, which are held even at the present day by many practitioners. He says: "On account of its bitter taste, it is also known as 'earth gall.' Supreme virtues exist in it when used in liver, spleen and joint diseases, jaundice and dropsy; for which purposes a powder, made from it, is mixed with anise-seeds and drunk in beer and wine. It induces the menstrual flow and restores a lost appetite. It rids the body admirably of pin worms, if an infusion of it is spread on a cloth and applied over the abdomen. It is a specific for rheumatism and typhoid fever.

"Its administration in cases of epilepsy produces an increase in the number of epileptic seizures due to its effect on cerebral engorgement. The coagulability of blood is diminished, resulting in the so-called paralysis of leukocytes. The fall of blood pressure after the administration of quinine is due unquestionably to its heart depressant action, and as an antipyretic its administration is attended by all the dangers without exhibiting the positive virtues of the coal tar products."

—R—

Unsuccessful Attempts to Transmit Influenza Experimentally.

Two extensive attempts have been made under the auspices of the U. S. Public Health Service and the U. S. Navy to transmit influenza experimentally. Inoculations were made of pure cultures of the influenza bacillus, of secretions of the upper air passages in the early stages of influenza, and of blood from typical cases of influenza, and other methods of transmitting the disease were tried. In no case was influenza developed. (Jour. A.M.A., Jan. 25, 1919, p. 281.)

—R—

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THE JOURNAL

of The

Kansas Medical Society

W. E. McVEY, M.D. - - Editor

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To arouse a spirit of antagonism in a Kansas legislature is has usually only been necessary to mention the subject of medical legislation. Members of the legislature are not unfriendly to the physicians, individually or as a class, and it is not perfectly clear why our efforts to secure favorable legislation should be so lightly regarded by the legislative body.

The medical profession has very rarely asked for legislation for its own benefit. It has expended money, time and energy in fruitless efforts to secure legislation that would protect the people against incompetent practitioners—legislation which was primarily and secondarily for the benefit of the people. We say these were fruitless efforts, for it was not until the people demanded that some regulations for the practice of medicine be made that the medical practice act was passed. Since that time our efforts to improve and perfect this law has been just as fruitless as before, for although we have succeeded in amending the medical practice act, its purposes have been practically nullified by the passage of other practice acts which provide for the licensing of various kinds of substitutes for doctors.

The people do not yet realize that these

are evasions of the laws which they demanded for their own protection, and that men and women are licensed to practice medicine who know very little of the human body and practically nothing of its diseases. Until they do realize this fact there is little hope for efficient regulation of the practice of medicine. However, it is our duty to keep trying and to point out to each succeeding legislature the needs for higher standards of qualification in those who attempt to treat the sick.

R

In the Surgical Clinics of Chicago (December) Bernstein has a very interesting clinical report on Infections of Hand and Fingers, from which we quote the following very valuable suggestions for the treatment of these cases: "Every opening must be made large enough. A drain must be inserted and then hot dressings applied. What happens when no drain is inserted and dry dressings applied? The edges of the wound become edematous and exude a serum which coagulates and seals up the opening. This is why hot dressings should be applied. It keeps the coagulum in solution and does not permit sealing. An important point to which I wish to call your attention is the flow of serum from the wound. Wright maintains that as long as serum is permitted to exude from an infected wound the condition is favorable. The serum bathes the wound and brings the lymph to the surface.

When its excretion is interfered with or is permitted to coagulate upon the surface of the wound, the infection takes a centripetal course. That is what is meant by the term "lymph-bound."

R

In the Army number of Medical Clinics of North America (September) some very interesting reports from medical officers in the various camps indicate how carefully the laboratory investigations have been made and how valuable the data so obtained will be in the practice of medicine. The report of Major Cecil on the pneumonias at Camp Upton shows that of 382 cases of pneumonia in which bacterio-

logic examinations were made, 161 were of pneumococcus origin and 182 were of streptococcus origin. Of the 182 streptococcus pneumonias, 118 proved to be due to the hemolytic streptococcus.

—R—

Now that the great war is over, a spirit of criticism is rampant. If any department of the government in any way connected with war activities has escaped the searching eye of the critic, it is only for the time being.

Little officers are calling the bigger ones to account and these are accusing the higher-ups of inefficiency. Even in civil life, men in official positions are being boldly called to explain their delinquencies and to account for their failures. Is it a favorable sign? Does it indicate that the people are very strongly impressed with the need for efficiency? Or, perhaps, is it the reaction from a considerable period of restraint?

—R—

The medical bill prepared by the commission which was appointed by Governor Hodges, has again been introduced for consideration by the present legislature. This bill provides for the appointment of a board of examiners which shall first examine the credentials of every applicant for a license to practice before he may appear for examination by either of the other boards of examiners.

—R—

Dr. S. S. Myers, formerly of Scott City, has removed to Greely, Colorado, where he expects to limit his practice to the eye, ear, nose and throat.

—R—

Dr. A. Haggart, formerly of Ottawa, has recently located at Elgin, where he expects to do a general practice.

—R—

OBITUARY.

Dr. John D. Freeman

Dr. John D. Freeman died at Stormont Hospital, Topeka, January 27, from pneumonia. He was born in 1871 at Geneva, Illinois. He was a graduate of the Uni-

versity of Wisconsin and received his medical degree from Rush Medical College in 1897.

Dr. Freeman came to Topeka in 1899 as Chief Surgeon of the Santa Fe Hospital here and held that position at the time of his death. He was recognized as one of the leading surgeons of the state. He was a member of the Shawnee County Society.

Dr. F. T. Allen

Dr. Frank Trimmer Allen, aged 69, died at his home in Neodesha, January 2. He was born in 1849 at Hillsboro, Illinois, and received his literary education there. He received his degree in medicine from the medical department of Northwestern University in 1873. He practiced in Bond County, Ill., until 1879 when he located in Kansas and at Neodesha. Dr. Allen has been recognized as a physician and surgeon of large experience and unusual ability. He leaves a wife and one daughter, Mrs. Dr. J. L. Moorhead. He was a member of the Wilson County Society.

—R—

Dr. S. G. Stewart.

Dr. Samuel G. Stewart, 74 years of age, died at St. Cloud, Florida, on Friday, February 7. Dr. Stewart has been one of the leading physicians in Topeka for the past thirty years. He was born in Oxford, Ohio, October 1, 1845. He received his degree in medicine from Starling Medical College in 1873.

Dr. Stewart was Professor of the Principles and Practice of Medicine and Clinical Medicine in the Kansas Medical College from its foundation until its merger with the University. He was a member of the American Medical Association and of the Shawnee County Medical Society.

For some years past it has been his custom to spend the winter in Florida and it was there that his fatal illness occurred.

—R—

Excerpts—By The Prodigal.

It is claimed that the most accurate investigators of the human mind have been the poets, particularly Homer and

Shakespeare. This accounts for the permanent hold these authors have on the cultured.

For soft spongy gums, massage them thoroughly with the finger and press down on them after each meal, after which cleanse with warm water and a soft brush.

There is no authentic case on record of hair turning white over night from fright, grief or suffering.

When the system is saturated with iodide of potassium, do not put yellow oxide of mercury in the eye. It will be worse than war.

A doctor to be a real doctor must see with the brain as well as with the eye.

More than 1,000,000 enlisted soldiers, during the Civil War, were under eighteen years of age, and 850,000 were from fifteen to sixteen years old. They made good soldiers. Our boys of the present have not forgotten the knack.

In the present war it has cost about \$25,000 to kill a soldier. About 72 per cent of the wounded were able to return to the firing line.

SPHAGUM MOSS.—"A surgical dressing. The Germans are not alone in using it. Sphagum moss is used by all the armies. Special machinery has been devised to prepare it for use. It is first washed and freed from all foreign substances and then is wrung out and sent to the drying room. After being thoroughly dried it is weighed and compressed in powerful hydraulic presses. It is being widely used now, giving much better results than cotton wool. Its healing powers were discovered quite by accident. A worker met with a serious injury in a peat moss litter works, and no appliances being handy, his fellows laid moss litter on the wound and bandaged it up. When the man reached a hospital the doctors were horrified at the dirty looking litter, and declared that the limb would have to be amputated. They found, however, that far from pois-

oning the wound, as they had feared, the wound had been actually cleaned by the rude emergency dressing. Thus was discovered sphagum moss, from the surgeon's point of view.—Review of Reviews.

PLURIGLANDULAR THERAPY.—The Prodigal has been looking over a brochure with the above title. It says: "Pluriglandular disorder is much more frequent than disorders involving a single gland of internal secretion; hence the reinforcement of an indicated organotherapeutic extract with one or more synergists many times radically alters the results for the better. Indeed may make the difference between success and failure."

Mono, or uniglandular, sero-therapy appears to be established. Poly, or pluriglandular, therapy is asking for recognition at the therapeutic table. The Prodigal has no voice in the refereeing, but it reminds him of his teaching the virtue of belladonna and a combination with its synergists, hyoscyamus, stramonium, etc. But later he convinced himself that mono-therapy got better results.

While visiting in Chinatown, San Francisco, he was in a Chinese drug store where the therapeutic agents on display were dried spiders, tarantulas, bugs of various kinds, lizards, snakes, shells, etc. A Chinaman came in and made a chattering noise and the druggist took some dried bugs, pulverized them in a mortar, did the powdered bugs up in a few papers, mumbled something evidently giving instruction how to take the bug dust, and the transaction ended by the transfer of a coin of the realm. The question is, Was that polypharmacy or pluriglandular therapy in the rough, or humbuggery?

If there is an objection to polypharmacy, or to the shot-gun prescription methods of therapy, it would appear doubly objectionable—taking the secretions of the endocrine glands outside the body and mixing them in the outer world and using them.

THERAPIES VS THERAPIES

And now comes the Physiotherapist. The

name is authorized and approved by the Surgeon General's office. The requirements are a graded school education and a practical knowledge of the following branches: Hydrotherapy, electrotherapy, mechanicotherapy, and massage. Hydrotherapy and massage are preferred. The aforementioned therapies are to be used on the disabled soldier in helping him to come back.

"The word *Therapeutics* is derived from the French word *Therapeutique* and is that part of medicine which treats of the discovery and application of remedies for diseases."

It is a pleasure for a has-been to look on and see that it is horse and horse between the number of disease-causing bugs and the overnight specialists to *do* the bug. Seriously, I believe in specialists, but a therapeutic specialist who has not been grounded in a medical education is liable to do more harm than good in practicing therapies. These methods are not fads for a physician to practice or to be practiced under his supervision. But to permit or encourage their practice by pseudos—that must be well guarded.

—R—

THE FORUM.

Answers to Correspondents.

MALAR BONE, M.D., F.B.S.D.C.

SENATOR S.—We fully appreciate your interest in the medical profession and your desire to secure some legislative enactments favorable to it. However, we do not believe that a compulsory eight hour law for doctors would be quite as practical as might be supposed. You see, even if one always used forceps, it might not always be convenient for one to knock off at the end of his eight hour trick.

We hardly think it adviseable to put the practice of medicine under the control of the Utilities Commission.

Yes, it would be quite proper to put the medical profession in with hotel and boarding house keepers and make it a penitentiary offense for any person to beat a doctor bill.

DR. M. M. M.—Have just read your

letter in regard to your little patient. As we understand it, the same school nurse who recommended that the child's tonsils and adenoids should be removed now insists that you must have left some adenoid or tonsillar tissue, because he does not yet seem to be bright and does not keep up with his classes.

We have heard of an occasional case of this kind. If you are sure there is no adenoid tissue left, it may possibly be that his father and mother were neglected in their childhood and did not have their adenoids and tonsils removed soon enough.

DR. P. P. P.—We have had some correspondence in regard to your charges of unprofessional conduct on the part of Dr. K. Your statement that Bill Short told you he had sciatica and you gave him some medicine for it, and that he afterward went to see Dr. K. who also prescribed for him seems to be borne out by the evidence. But the fact is that Bill lied to you. He did not have sciatica at all. Dr. K. examined him and found that he had a tuberculous hip-joint. Maybe you had better have Dr. K. examine your next case before you prescribe for it, or if you have time you might examine it yourself.

DR. B. P. S.—Yes, there really are cases of chronic arthritis that never had any catarrhal symptoms, that had had their teeth extracted and had been tonsillectomized many years before the arthritis occurred. Yes, we agree with you, there must be an occasional case of arthritis, and possibly some other diseases, for which the tonsils and teeth are not responsible.

LIEUT. R. G.—We were pleased to hear from you and to know that you are learning so many new things—especially new ways of doing things. It is really worth while to know all the ways to do things. We just heard an ex-army officer say:—"There are two ways of doing everything, the right way and the army way."

DR. F. A. C. S.—In regard to the case of sciatica in which you say you have removed some gall-stones, enucleated the tonsils and extracted the teeth, would

suggest that you do a splenectomy and, if that results in no improvement, that you give her an ounce of castor oil and a half ounce each day for a week.

DR. B. D. C.—We are unable to inform you if Dr. G. really has studied in foreign parts. It is safe to assume, however, when a doctor makes frequent occasions to tell of his studies abroad, that either his reputation or his knowledge needs bolstering.

CAPT. M. R. C.—No, we do not believe your commission will obtain for you a license to practice medicine in Kansas. Of course we understand the examination you passed in getting your commission was very rigid, especially the questions in obstetrics, but the Kansas Board of Examiners is very punctilious in this matter of determining qualifications to practice in this state. For some reason they like to ask a few questions of their own invention.

—————R—————

Recommendations of President, Councilors, and Committee of the Kansas State Medical Society, to the Governor, the Senate, and the Legislature of the State of Kansas.

We, the undersigned committee of the Kansas State Medical Society, respectfully present the following recommendations to the Governor, the Senate, and the House of Representatives of Kansas:

1. Upon no other profession or class of men have the burdens and sacrifices necessitated by this war fallen so heavily as upon the medical profession. The first request of the Allies after the United States entered the war was for one thousand physicians. The first American army officer killed was Lieut. William Thomas Fitzsimmons, M.E.R.C., a graduate of the School of Medicine of the University of Kansas. We therefore believe that in recognition of these facts, the state should give consideration to the wishes and needs of the medical profession, which ultimately are for the best interests and health of the people. It is further recommended that a hospital be erected as a memorial to the first American officer killed in France—Dr. William Thomas Fitzsimmons.

2. We therefore recommend that the

State build and support a hospital, or hospitals, to care for crippled and deformed children, acute surgical and medical cases, and maternity patients who may require attention. We believe that this work could be done most economically and efficiently in connection with the School of Medicine of the University of Kansas at Rosedale, which has been doing this kind of work and has the organization and staff to care for it.

3. That the war and the influenza epidemic have emphasized the necessity of the State's maintaining and supporting adequately its hospitals, its School of Medicine, a Training School for Nurses (including Public Health nurses) and its laboratory for the diagnosis of venereal diseases.

4. That the chairman of this committee has personally visited the hospital and laboratories at Rosedale and investigated the situation there; and upon his report, the committee desires to recommend that appropriations be made at this session of the legislature for the following urgently needed purposes.

a. The purchase of additional ground in Rosedale, so that a complete plant may be erected.

b. The erection of a heating plant and power house.

c. The erection of a hospital with suitable accommodations for the kinds of cases mentioned above, including crippled and deformed children; such hospital to be known as the Fitzsimmons Memorial Hospital.

Respectfully, signed
W. S. LINDSAY, President
L. F. BARNEY, Secretary
J. T. AXTELL, Chairman
Committee.

January 26, 1919.

—————R—————

SOCIETY NOTES.

BOURBON COUNTY SOCIETY.

The regular meeting of the Bourbon County Medical Society was held in the Library building at Fort Scott, January 20.

After the transaction of the usual business several reports of cases were presented to the Society.

Dr. Newman reported five cases of cesarean operation with five living mothers and five living babies. In one case there was a large fibroid tumor which

came down ahead of the fetus. There was one case of eclampsia and three cases of placenta previa.

Drs. Newman, Hunter and Young reported a case of sarcoma of the kidney in a two and one-half year old baby. An exploratory operation revealed a large and adherent tumor.

Dr. Payne reported a case of intussusception of the splenic flexure of the colon in a boy of four years, following a diarrhea of three days duration, and twelve hours after the onset of symptoms the operation was done, with uneventful recovery.

Dr. Hunter reported a case of gangrenous Meckel's diverticula of the ilium with operation and recovery. Dr. Hunter also reported a case of epidemic cerebro-spinal meningitis in a young man recently discharged from the navy. Meningococci were found in the spinal fluid.

Dr. Young reported three cases of epididymitis following attacks of influenza.

At the next meeting the following program will be presented: Eclampsia, by rD. Payne; Abnormal Epithelium and Endothelium by Dr. Young; Tubercular Meningitis by Dr. Cummings.

C. F. YOUNG, Secretary.

BARTON COUNTY SOCIETY.

The Barton County Medical Society met in Great Bend on January 31, with the following members present: Drs. Kendall, Lightfoot, Button, Connett, of Great Bend; Drs. Brown, Embrey and Pennington of Hoisington.

The following officers were elected: President, H. C. Embrey, Hoisington; vice president, T. J. Brown, Hoisington; secretary-treasurer, B. S. Pennington, Hoisington; delegate, Dr. Kendall, Great Bend; censor, A. H. Connett, Great Bend.

CHEROKEE COUNTY MEDICAL SOCIETY.

The Cherokee County Medical Society met in Columbus, Kansas, February 5, 1919. Members present, Drs. Loudermilk, Shelley and McKinney of Galena, Drs. Johnson, Brookhart and Graham of Co-

lumbus, Dr. Iliff of Crestline, and Dr. Reid of Mineral.

The following officers were elected for 1919: F. L. McKinney, president; W. H. Iliff, vice president; J. Dale Graham, secretary-treasurer; R. C. Loudermilk, censor; F. L. McKinney, delegate, and H. H. Brookhart, alternate.

Program for this year will be confined to the discussion of various phases of tuberculosis. Next meeting will be in Galena, March 5.

J. DALE GRAHAM, Secretary.

—————R—————

First Aid Instruction in Public Schools.

A knowledge of ordinary first aid methods has been generally recognized by public health officials, medical organizations and individuals as essential because of the increasing complexities of modern industrial life.

Convincing proof of the necessity for the work of the Red Cross in first aid instruction will be found in the study of the following facts:

It has been conservatively estimated that between 90,000 and 100,000 fatal accidents occur annually in the United States, and that five times that number of accidents occur which so disable individuals that they can no longer earn their own living. Computing the earning capacity of each of this latter group at the low rate of \$500 per annum gives an aggregate loss of wages of \$250,000,000 annually. These figures, of course, take no account of the suffering and sadness brought into thousands of homes, which cannot be measured in terms of dollars and cents, the charges for medical care, the expense incurred by legal claims and damage suits, or the loss to employers.

According to the Interstate Commerce Commission there were 206,723 casualties on the steam railways of the United States for the year ended December 31, 1916. Of these 10,001 were deaths. These figures show an increase over the year ended December 31, 1915, of 1,371 in the number

of persons killed and 34,835 in the number injured.

The United States Bureau of Mines reports for 1916 show that out of a total of 720,971 men employed in the coal mines of the United States, 2,226 were killed, or, to put it more graphically, one life was sacrificed for every 265,000 short tons of coal produced.

Recognizing these facts, the American Red Cross has begun a movement through the various divisional offices, with the consent and co-operation of the State Superintendents of Public Schools concerned to place on the school curriculum of all high schools a course in first aid instruction.

The American Red Cross has for many years supervised the formation and teaching of classes in first aid. These classes were voluntary, and designed for adults. The greatest number of those availing themselves of this course were women who through this course became fitted to take care of most household emergencies, though minor usually in character from an overwhelming percentage of all injuries. The greatest number of severe injuries occur among men about their work. With this fact in mind the American Red Cross has endeavored to reach this type of injury, and has trained many men in factories and mills.

It is obvious that this type of teaching is unsatisfactory as it is all voluntary and depends wholly upon the enthusiasm and energies of a certain few who may see the necessity for this work and develop the class. It will also be noted that the class must be held outside of working hours, so that the class as a rule are not as receptive to instruction as would be generally believed. It has been found that a majority of the classes formed were women. The one place then where we can be sure of reaching a larger number of the male sex, and of reaching both sexes at a time when right reactions are readily set up, is in the high or preparatory school. And the ideal time for such teaching is in the second year of such schools, because having mastered the principles of first aid,

the pupil has an opportunity to apply them to all the little mishaps that characterize school activities in the gymnasium, in the athletic field, in the manual training shop, about their homes and outdoor sports and games.

It is only necessary to cause you to think how many children gather about an injured person, an ambulance or an accident of some kind, to show you the natural enthusiasm which exists in children for this subject. The proposed course will be one of the most interesting of their high school work and because of the natural enthusiasm the greatest possible good can be accomplished.

Influenza.

Clinical observations on 600 cases of influenza at the U. S. Naval Hospital, League Island, Pa., are reported by F. J. Dever and R. S. Boles (Philadelphia), and E. A. Case (Lansdowne, Pa.), League Island, Pa. (Journal A.M.A., January 25, 1919). One hundred and sixty-eight of the patients developed pneumonia, forty-eight of whom died. The epidemic continued unabated from September 12 to 17, when the crisis was reached. It seemed to spread more rapidly among men living in barracks than among those living in tents. In general the prognosis in uncomplicated cases is good as to life. Several cases of acute pulmonary tuberculosis were observed following an attack. It is probable that latent tuberculosis may be made active by the influenza infection and with existing chronic diseases such as nephritis, influenza is a serious matter. No specific treatment has been found to date. The measures used are detailed, the principal of these seeming to be rest in bed, keeping the emunctories free, acetylsalicylic acid in 5-grain doses when muscular pains are severe, large quantities of water, and frequent stimulation. Food administration was governed by the patient's appetite. The pneumonia was treated symptomatically in all cases. If Type I pneumococcus was found, the specific serum was employed. Venesection was apparently without benefit. As a sort of last straw, a stock vaccine for influenza was used in fifty cases as a preventive, and as a curative agent in fifty uncomplicated cases. As a preventive it was given every forty-eight hours, four doses to each patient, gradually increasing from 0.3 c.c. to 1 c.c.

in the third and fourth doses. In no case was there any severe reaction and none of the individuals contracted the disease. Of course, other safeguards were used, such as face masks. A few of those not injected, but wearing face masks, became victims, but the authors consider a properly fitting mask a fair protection. In the fifty uncomplicated cases treated with vaccine, none of the patients developed pneumonia, and but one pleuritis, and the disease was, with few exceptions, definitely shortened. The effects of the vaccine were the more striking the earlier the vaccine was administered. While the number of cases is too small for generalization, the use of vaccine seems safe and even desirable. The laboratory examinations revealed *B. influenzae* in pure culture from the sputum in only four cases though an organism resembling it occurred in a good percentage. Blood cultures were negative in all but one of twenty-six cases. Type determinations of the pneumonia were made by the Avery method in forty-two cases. In twelve specimens of sputum the result was unsatisfactory, the highest percentage was of Type IV. Blood counts showed a tendency to leukopenia in uncomplicated influenza, well marked in some cases. In the complicating pneumonias, leukocytosis was present in the majority. There was nothing characteristic in the differential counts. Only two necropsies were obtained, each showing consolidation of the lower part of the lung, and in one case edema of the air containing portions.

—R—

Influenza Pneumonia.

The report on the relation of bronchopneumonia to influenza as observed at Camp Lewis, American Lake, Wash., is made by the Camp Lewis Pneumonia Unit, of which Dr. W. J. Kerr is the head at the Camp Lewis base hospital (Journal A.M.A., January 25, 1919).

This camp was completely organized with roentgen-ray and laboratory service when pneumonia first appeared. The atypical signs were early recognized, the usual signs in young adults being conspicuously absent. Frank consolidation with high temperature was the exception. Most of the patients gave a history of typical influenza symptoms. On physical examination the findings were not marked. Slightly diminished resonance was usually observed over one or both lung bases posteriorly. The breath sounds were variable, but within from forty-eight to seventy-two hours there was either a marked ex-

tension of the process, with definite though atypical signs of diffuse bronchopneumonia, or the temperature dropped to normal and the lungs showed signs of resolution. In the severer cases the temperature remained elevated, with only slight increase in pulse and respiratory rate for several days, and then fell to normal. In fatal cases the process extended over several or all lobes of both lungs. There was consistent low white pneumococcus, with a nonhemolytic streptococcus. Influenza bacilli were found only in a few cases early in the epidemic. Blood cultures were positive in 2.9 per cent, mostly pneumococcus. Post mortem examinations revealed a bronchopneumonia of varying degree, but usually extensive, characterized by scattered areas of pneumonic consolidation varying in size. The use of the roentgen ray was invaluable, as showing the consolidation, etc. They say that it appears amply demonstrated "that the process, whether mild or severe, is etiologically and pathologically the same; that there are all gradations from a slight involvement of the bronchioles with adjacent alveolar infiltration to an extensive involvement of entire lobes simulating lobar pneumonia; and that the cases were mild or severe, depending on the resistance of the individual or variations in the virulence of the organisms, rather than the accepted idea that the pneumonia complicated one case and not another." A later and fuller report with laboratory and neurologic data is promised at an early date.

—R—

Mitral Regurgitation.

Mitral regurgitation which has been assumed to be the easiest of all valvular diseases to recognize is, according to the experience of M. A. Rothschild, New York (Journal A.M.A., February 1, 1919), the most difficult. The presence of a systolic murmur at the apex transmitted to the axilla has had its importance overvalued. The number of adventitious sounds heard in the cardiac examination in examining recruits is surprising, and deviations from the normal are almost the rule. Systolic, apical or basic murmurs are heard in at least 50 per cent of all men examined, especially immediately after exercise. Mitral regurgitation may be estimated the most prominent or the least so according to the interpretation of the examiner, and certain criteria should be established to standardize the work. Rothschild gives the observations at the camp to which he is attached, and says they have used these

criteria for the diagnosis of mitral valvular disease: (1) cardiac hypertrophy; (2) a systolic, apical murmur, and (3) a definite history of one or more attacks of acute articular rheumatism (not growing pains or tonsillitis). In these criteria such physical signs as an accentuated or split pulmonary second sound were purposely omitted as of no value, and abdominal pulsation of the type corresponding to the contractions of the right ventricle is also of no differential value. The character and irregularities of the pulse are of even less significance and the intensity of the propagation of the murmur is at best of doubtful significance, though it is extremely difficult to absolutely disregard it. In Rothschild's opinion it signifies more in a slow acting heart. The differential diagnosis of mitral regurgitation must, he says, be made from the following conditions: (1) functional cardiovascular disorder, disordered action of the heart, "irritable heart of soldiers," neurocirculatory asthenia; (2) accidental systolic, apical murmurs. The differential diagnosis from functional cardiovascular disorders is not very difficult. The absence of cardiac hypertrophy plus the other physical signs other than cardiac manifestations make it fairly simple. The intensity and propagation of the murmurs may not differ from those of true valvulitis, but the other symptoms and signs of neurocirculatory asthenia are absent in cases of true organic mitral disease. One may complicate the other, however, and make difficulty. Excluding the neurocirculatory asthenia group we have cases with no hypertrophy, but with the systolic, apical murmurs, and these give the most difficulty. It is not a matter of great surprise, however, that such murmurs occur, but that they do not occur more frequently. The effect of exercise on the patient must be carefully observed, and any peculiar look of anxiety and quickening of respiration are all important signs. There are two classes of these cases: (1) those without symptoms, and (2) those with symptoms. Those without symptoms are fit for full military service, but the class with symptoms is a difficult one to label and they are probably early cases of organic valvular disease. Electrocardiographic evidence of left ventricular predominance or the diagraphic evidence of the so-called mitral configuration are of service in diagnosing these cases. Rothschild follows Lewis in disregarding the systolic murmur per se. The soldier is disqualified because of cardiac

hypertrophy or because of poor exercise response. His service is limited because of a definite rheumatic fever.

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Incidence of Pneumonia.

While there is little doubt, says David Greenberg, New Haven, Conn. (Journal A. M. A., January 25, 1919), that meteorological conditions have a distinct influence on the occurrence of pneumonia, and although much investigation has been done along this line, the published findings have been varying and inconsistent. He refers to a number of these showing this fact. While making an investigation of death rates from pneumonia in the North Atlantic States he noted that they were markedly higher than those from the Pacific Coast, and was induced from this to attempt to find out whether the common notion that this is due to moist conditions and low temperature is correct. Methods followed by other observers were used by him without satisfactory results. He was fortunate, then, in finding a new method of plotting his records, devised by Prof. Huntington of Yale, depending on the use of what he calls the climograph. He describes the method and its use. With the exception of one city, the deaths studied were all of lobar pneumonia, excluding bronchopneumonia cases, which are so often only sequels or complications of many other diseases. The charts with the paper show the relation of pneumonia to relative humidity and temperature variability as plotted in the curves of the climograph, and also in relation to wind. The curves of other diseases, diarrhea and enteritis among children, which occur under conditions of high temperature were also plotted out as a check to the method, and as an additional check, cancer was also studied as a disease that shows no seasonal preference. He sums up as follows: "In studying the death rate of lobar pneumonia in its relation to meteorological conditions, it has been found that: 1. Temperature per se is the most important controlling factor. 2. A low relative humidity is conducive to a high death rate, and a high relative humidity to a low death rate. 3. Increases in the death rate correspond to increasing temperature variations." Eleven charts and three tables with corresponding legends accompany the article.

Rational Drug Therapy.

Jacob Diner, New York (Journal A.M.A., January 25, 1919), says that the physician should always bear in mind that drugs do not cure but that they may be made valuable adjuncts in restoring normal action in disease. The taking of medicine should not be made a punishment, and it is the duty of the prescriber to administer the drug in as palatable a form as possible. It often happens that the desired physiologic action fails to appear because of improper administration or selection of drugs. Therefore, Diner takes up certain groups of remedies, pointing out how the proper selection can be made. First soporifics, of which the chloral group depresses the central nervous system even to eventually paralyzing it. It has no special specific effect on pain, but diminishes the reflexes of the spinal cord, those of the medulla oblongata last. Therefore, it does not often affect the respiratory center to any extent. In a case of insomnia due to pain it is contraindicated while it is eminently the remedy of choice in insomnia due to nervous excitation, especially of spinal or reflex origin. Being irritating to the skin and mucous membranes it should be administered in high dilution and preferably with some bland substance. Opium and its derivatives, on the other hand, have a marked selective action on pain and respiration, reducing both in doses too small to affect general consciousness. In administering them the possibility of habit producing must always be considered. Bromids act directly as depressants on the central nervous system, but they are slower in action and rather rapidly eliminated, especially in the presence of chlorids, and are irritating to the mucous membrane in concentrated solution. Frequent small doses will bring about more physiologic response than one large dose and when the concentration of bromids is to be maintained in the blood and tissues, that patient should be kept on a salt-free diet. As regards stimulants, trychnin has selective action on the spinal cord. The caffeine group acts both on the central nervous system and on the kidneys but the theobromin group has little effect on the nervous system. In lobar pneumonia with increased pulse and respiration and mental confusion or delirium, caffeine is contraindicated, as in the recent epidemic, and theobromin sodium silicylate or some saline diuretic would be better. On the other hand, caffeine would be of use in case of mental or psychic depression and

particularly in depression incident to poisoning. Atropin is also contraindicated in the pneumonia cases excepting when it is desired to check secretion. Camphor would also not be indicated because in physiologic doses its action on the heart and circulation is relatively small. The digitalis group, however, is eminently satisfactory in these conditions. Digitalis is relatively slow in its action and also more permanent while strophanthus is indicated for emergency cardiac stimulation. In giving magnesium sulphate few physicians remember that its rapidity of action is increased by its dilution and it should be given with a large amount of water if quick action is desired. Carbohydrate digestion, initiated in the mouth, is continued for some time in the cardiac end of the stomach until the gastric secretion reaches a certain degree of acidity, about thirty minutes after food reaches the stomach. Hence the impropriety of administering pepsin and hydrochloric acid immediately after eating. Pancreatin belongs to the proteins and it should be administered in a form in which it will not readily be acted on by the gastric secretions, and should be used toward the end of the normal gastric digestion two or three hours after eating. Another thing to be remembered is connection with enzymes is the fact that alcohol inhibits their action and giving them in the form of elixirs or wines seems illogical.

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Atropin and Antianaphylaxis.

J. H. Stokes, Rochester, Minn. (Journal A.M.A., January 25, 1919), takes up the subject of the acute nitritoid or anaphylactic reactions to the intravenous injection of arsphenamin which have become more or less familiar to the medical profession as following the use of certain brands of the drug. One of the essential facts, he says, in the production of anaphylactic shock may now be regarded as change in the dispersion of the colloids of the blood serum. Friedberger and Tsuneoka have found that the injection of powder, such as kaolin, into the blood stream causes anaphylactic shock, and MacKee and others observed in 1912 that the intravenous injection of arsphenamin in acid solution produced a precipitate and reaction in the patient proportional to the concentration of the solution and the rate of injection, that is, the rate of formation of the precipitate in the blood stream. Reasoning by analogy the closely similar picture of nitritoid crisis may be anaphylactic shock caused by the formation of

precipitates in the blood. This reasoning has been supported by the recent work of Danysz and Berman. As to the cause of the arsphenamin reaction, it cannot be regarded as completely settled, as there remains to be explained the large body of observation on variations in the toxicity of arsphenamin itself. In his own experience Stokes has found that while using some German preparations there was scarcely a day passed without some unpleasant reactions, while with 7,000 subsequent injections with other preparations they have hardly been able to carry on the work necessary in writing this article on account of the rarity of such reactions. Work of this kind can be undertaken only in patients with special idiosyncrasy to arsphenamin and such cases are not so common. The report of one case thus observed is given in the article. It was surrounded with all the precautions that could be devised and Stokes believes that it was a reliable test. Atropin was used to inhibit the reaction and with such success by the injection of one-fiftieth of a grain as to support his views of the condition and its remedy. An interesting point in the observation was suggested by the non-disappearance of the delayed toxic erythema. Since its successful employment in the case reported, they have used the induction of antianaphylaxis against acute arsphenamin. Stokes thinks the subject is worthy of further study.

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Irritable Bladder in Women.

C. A. L. Reed, Cincinnati (Journal A.M.A., February 1, 1919), describes irritable bladder in women as being a condition in which severe pain in urinating and frequent desire to urinate make life miserable for the patient, and trying to the physician. The underlying condition is abnormal sensibility of the lining of the bladder itself, which may be caused by conditions either external or internal. Those working from the outside usually act by pressure, such as in cases of pregnancy, uterine displacements or tumors. Among the conditions arising within the bladder and that have a causative bearing on the symptoms acute infection, generally gonorrheal, tuberculous infection, local growths, benign or malignant; calculi; diverticula, etc., may be named. In a certain proportion of cases, circumscribed ulceration, the so-called Fenwick ulcer, near the outlet has been found the essential condition. Another form of ulcer is specially mentioned, which might be desig-

nated as the Hunner ulcer, first described by Dr. H. L. Hunner; or, better, as the punctate ulcer of the bladder, as being more descriptive. Importance of differential diagnosis in these cases from early thorough examination is emphasized, and three cases are reported. The symptoms are those of the irritable bladder first mentioned, and the urinalysis findings are usually negative. Reed reproduces the description given by Hunner as he has found it most accurate and helpful. He calls attention to a glazed dead white appearance of a portion of the bladder mucosa as seen through the cystoscope. Sometimes there are small congested areas in the immediate neighborhood of this, which sometimes ooze blood and are often surrounded by an area of edema. In certain of these cases, Reed has observed a granular appearance suggestive of tuberculosis, but which we now know, from Hunner's research, is due to the development of minute cysts with mucous lining. The diagnosis of punctate ulcer is based on the history of the case, the existing symptoms and the urinalysis and cystoscopic findings. The cases have not yet been fully determined, but the possibility of focal infection is admitted, though longer observation is required. The pathology, so far as developed, seems to be that of a chronic interstitial nephritis, more or less involving the bladder wall. The treatment seems to be reduced to surgery, the complete excision of the ulcer-bearing area. The original method devised by Hunner was extraperitoneal, and was employed in the first of Reed's cases, while his other two were treated by a transperitoneal operation.

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Hemolytic Streptococci.

A preliminary report of cultural and serologic studies of hemolytic streptococci is made public by C. D. Hamilton (Canton, Ohio), and L. C. Havens (Cambridge, Mass.), Camp Wadsworth, Spartanburg, S. C. (Journal A.M.A., January 25, 1919). Its purpose is to show that the hemolytic streptococci can be grouped, according to their agglutination reactions, into more or less definite types, and that a protective serum for each group is possible of production. The cultural and serologic characteristics of strains from healthy carriers, acute bronchitis and bronchopneumonia sputums and necropsies have been studied by them. Many of the strains differ in appearance in blood agar colonies, but the sugar reactions are generally similar.

Charts showing the relation between the different groups are given for 110 strains. In 48 per cent of these it was found that they were agglutinated in high dilution (1:5,000), and there were three other groups varying according to their degree of agglutinability. The bactericidal effects of the groups were tested, and they were found specific in each. The method of making the tests is described, and protection tests on mice are also reported. These groups were obtained by the serologic reactions of the different strains. Their cultural characteristics have no relation to their immunologic grouping, but the serums of immunized rabbits with strains of hemolytic streptococcus were found to protect mice against an infection with a homologous strain, but not those serologically different. Certain master strains can be isolated by their serologic reactions, and a therapeutic method against infection by hemolytic streptococci is suggested as possible.

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How the H. K. Mulford Company Prepared to Meet the Influenza Pandemic of 1918.

Realizing that the epidemic of influenza raging in Europe was likely to invade the United States, the H. K. Mulford Company early prepared to meet the demand for serums and vaccines required for the prevention and treatment of the disease and its complications.

The disease was known to be due to a mixed infection in which the influenza bacillus (Pfeiffer's bacillus,) pneumococcus, streptococcus, micrococcus catarrhalis and the staphylococcus were the invading causative micro-organisms.

Early in September the facilities of the Glenolden Laboratories were offered to the hospitals of Philadelphia to aid in the investigation of the cause of influenza and particularly the pneumonia complications. Material was sent from the Philadelphia Hospital, U. S. Naval Hospital and other institutions for study. Fifteen strains of the influenza bacillus and virulent strains of streptococcic hemolyticus taken from the material sent in from the hospitals were added to the influenza bacterins to insure their greater specificity.

The pneumonias following the attacks were known to be due to the pneumococcus and streptococcus, consequently anti-pneumococcic and antistreptococcic serums

were prepared in large quantities to meet the requirements.

For several years previous, extensive studies had been made by Dr. Parker Hitchens, former Director of the Laboratories, to determine the character of the infections responsible for influenza, acute bronchitis and common colds, which year after year regularly occur in the United States. The microorganisms causing these diseases in former epidemics of influenza are the same as those responsible for the pandemic of influenza occurring in 1889-90, and also the present pandemic.

These bacterins, known respectively as Influenza Serobacterin Mixed and Influenza Bacterin Mixed have attained high reputation both as prophylactic and therapeutic agents.

It is too early to supply exhaustive statistics, but enough evidence has been accumulated to fully justify the employment of Influenza Serobacterin or Influenza Bacterin Mixed, for the prevention and treatment of Influenza. It has been amply demonstrated that patients immunized by the bacterins rarely acquire Influenza and those who take the disease are practically insured against complications of the pneumonias which have proved so fatal during the recent epidemic.

Fact and Opinion on the Influenza Epidemic.

At the recent meeting of the American Public Health Association the discussions relative to the etiology of the present epidemic resolved themselves into the belief that the bacillus of influenza is not the primary etiologic factor and that the actual cause is as yet unknown. In the argumentation for and against the face mask as a means of preventing the spreading of the disease, sight was lost of the fact that definite evidence has been presented to show that the wearing of a mask prevents the diffusion of pathogenic organisms of which we have definite knowledge. A paper was presented which indicated to the satisfaction of most listeners that a significant factor in the spread of the epidemic in army camps was the inadequate washing of mess kits (Jour. A. M. A., Dec. 21, 1918, p. 2074)..

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The Goldwater Ordinance.

In 1914 the Department of Health of the City of New York revised the Sanitary Code so as to require that no "patent medicine" should be sold in the city of New

York unless the name of the potent ingredients are declared. The ordinance was bitterly fought by the "patent medicine" interests, the fight being led by E. Fougera and Co., E. N. Crittenton Co., and H. Planten and Son. Now the Appellate Court of New York has decided that the ordinance is void, but has upheld the principle that a disclosure of the formula of medicines may be required. The underlying principle of the ordinance was the right on the part of the city to require disclosure of ingredients, and that right the Appellate Court unholds (Jour. A. M. A., Dec. 21, 1918, p. 2093).

New and Nonofficial Remedies.

During December the following articles have been accepted by the Council on Pharmacy and Chemistry for inclusion with New and Nonofficial Remedies:

Non-proprietary articles: Benzyl Benzoate; Emetine Bismuth Iodide.

Abbott Laboratories: Emetine Bismuth Iodide—Abbott.

Hynson, Westcott and Dunning: Benzyl Benzoate—H. W. & D.; Solution of Benzyl Benzoate, Miscible—H. W. & D.

Merck & Company: Diethylbarbituric Acid—Merck; Diethylbarbituric Acid—Merck tablets, 5 grains; Sodium Diethylbarbituric Acid—Merck; Sodium Diethylbarbituric Acid—Merck tablets, 5 grains.

H. K. Mulford Company: Bismuth Emetine Iodide—Mulford; Cachets Bismuth Emetine Iodide—Mulford, 5 grains.

E. R. Squibb & Sons: Chlorinated Eucalyptol—Squibb.

Takamine Laboratory: Arsaminol—0.1 gm. tubes, 0.2 gm. tubes, 0.3 gm. tubes, 0.4 gm. tubes, 0.5 gm. tubes, and 0.6 gm. tubes.

Sterilizing the Nasopharynx.

Evidence is accumulating of the value of Dakin's antiseptics for sterilizing the throat and nose of persons exposed to or suffering from Spanish influenza and other diseases transmitted by the secretions of the upper respiratory tract. The simplest and most convenient of these remedies to use is Chlorazene, which is available in tablet form for the preparation of aqueous solutions, which may be used for spraying or gargling. Such solutions are convenient, can be made up by anyone with ordinary intelligence and are exceedingly efficient.

When possible the aqueous solution should be supplemented by the oil spray

of Dichloramine-T dissolved in Chloroform, a 1 to 2 percent solution being employed for this purpose. This should be applied at least twice daily, where possible by the physician himself or by the nurse. The use of Dichloramine-T assures prolonged contact with the mucous membrane for an exceedingly powerful germicide, which can be used without danger to the patient.

The extensive experimental work conducted by The Abbott Laboratories, preliminary to placing the Dakin products at the disposal of American physicians, seems to be justified by the splendid results which are being obtained.

Emetin Bismuth Iodid.

The Council on Pharmacy and Chemistry reports that because of the apparently good results obtained with it, emetin bismuth iodid has been accepted for New and Nonofficial Remedies. Emetin bismuth iodid is responsible in water and dilute acids, but is decomposed by alkalis, and thus should pass the stomach unchanged but exert its action in the intestines. Those who have reported on the use of the drug in amebic dysentery report that the disappearance of ameba from stools was generally complete and apparently permanent even in chronic cases of carriers and in cases where the hypodermic administration of emetin has failed. Purging and vomiting, however, are not entirely avoided. The drug is usually given in a single dose of three grains at the midday meal for twelve days (Jour. A.M.A., Dec. 14, 1918, p. 2013).

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Influenza.

J. W. Nezum, Isadore Pilot, F. H. Stangl and B. E. Bonar, Chicago (Journal A. M. A., November 9, 1918), report on the epidemic of influenza observed at the Cook County Hospital. From September 23 to October 29, more than 2,000 patients were admitted to the wards, and of these, 642 died, a mortality of 31 per cent, the age period of highest mortality being between 25 and 30 years. At the time of writing the mortality seems to be on the decline, but while it lasted the epidemic seriously crippled the medical and, more especially, the nursing staff. More than fifty of the nurses and twelve of the physicians contracted the disease, and among them three deaths occurred. The influenza bacillus was isolated in only 8.7 per cent of the total cases and in only one instance did it

appear to have caused the pneumonia. It was met with more frequently among 125 soldiers who were admitted, than among the civilian patients in whom it was isolated only exceptionally. Pneumococci were the predominating organisms in the sputum, throat and lung cultures, both during life and at necropsy. The possibility of a filtrable virus suggested an experimental study. Washings from the nose and throat of typical cases were filtered through Mandler and Berkefeld filters of medium porosity and the cultures of the clear filtrates inoculated into the anterior nares of volunteers and into monkeys, without results. Of the pneumococcal types, which were present altogether in 72.6 per cent, Type I was the least frequent, and Type IV the most common, Type II being second. Of eighty-six pregnant women admitted to the maternity ward with influenza or pneumonia, twenty-one died shortly after miscarriage, and twenty before this could occur, the mortality being, altogether, 45.5 per cent.

Chloroform Analgesia.

Torald Sollman, Cleveland (Journal A. M. A., August 24, 1918), speaks of the desirability of a suitable, prompt, brief, safe and, if possible, pleasant method of analgesia, where full anesthesia is not actually necessary. He recommends the use of chloroform, using a fixed dose for simply relieving pain and not causing unconsciousness. The chief problem was obtaining a method of administration for this purpose. He made experiments on man, accurately measuring the amount that could be safely used. Practically ideal results were secured by the use of 5 c.c. of chloroform taken up on a piece of cotton about the size of a lemon or larger and held directly to the nostrils with the left hand of the subject, who then breathed deeply and quietly, occasionally testing the sensation. On several occasions the subject passed through the events of the ideal induction of anesthesia, the floating sensation, prickling, warmth confusion, drowsiness, and in one case probably actual unconsciousness. In all others the subject felt almost asleep, but could answer questions coherently except during the maximal effect. The analgesia reaches its maximum in four or five minutes, and by this time the chloroform has evaporated, but the tolerance of pain continues to a great extent. This method was more effective for the special purpose than any other anesthetic, including the Hewitt chloro-

form-ether mixture and the Billroth A. C. E. mixture. The fixed dose should be rigidly followed or rather not exceeded. No attempt should be made to produce anesthesia by this method.

Notice.

The Annual Report of the Surgeon General, U. S. Army, for 1918, (including statistics for the calendar year 1917 and activities for the fiscal year ending June 30, 1918), has just been issued from the Government Printing Office. It contains a comparative study of the health of the Army, 1820-1917; an account of the health of the mobilization camps and of the Army by countries; a consideration (70 pages in extent) of the principle epidemics in the camps; and a discussion of fractures and operations. Nearly 200 pages are devoted to the special activities of the medical department:—with the American Expeditionary Forces, and in the divisions of sanitation, hospitals, supplies, laboratories and infectious diseases, internal medicine, general surgery, orthopedics, head surgery, neurology and psychiatry, psychology, food and the Dental and Veterinary corps. In addition to the usual tables of illness, discharge for disability and death, there are given tables of battle wounds and operations; of complications of various diseases and of case mortality. The text is illustrated by 73 charts. Altogether the report is a study of health and morbidity in an Army of over 1,500,000 men, for the most part yet in the period of training. It should be of interest to epidemiologists, vital statisticians and army medical men.

The Quality of the Market Supply of Procaine.

The local anesthetic procaine (first introduced as novocaine by the Farbwerke vorm. Meister, Lucius & Bruening, Hoechst A.M. Germany) is now manufactured by the Abbott Laboratories, the H. A. Metz Laboratories and the Rector Chemical Company. The products of these three firms were accepted for New and Non-official Remedies after the A.M.A. Chemical Laboratory had reported specimens chemically satisfactory and the Cornell Pharmacologic Laboratory had determined that they were not unduly toxic. In accordance with its announcement to report from time to time on the quality of American made synthetics, the Council on Pharmacy and Chemistry now publishes a re-

port on the quality of the procaine now supplied to physicians. The examination demonstrates that the three brands were of a satisfactory quality. Some of the specimens of procaine-Abbott and procaine-Rector had a yellow or light brown tinge (a specimen of procaine-Metz "novocaine" recently sent the Council also had a slight yellow tinge), but so far as the evidence goes there is nothing to indicate that the discolored specimens are seriously impure. The Council considers the use of the discolored product justified in the present emergency, but urges that for the future a colorless preparation be supplied. (Jour. A.M.A., Jan. 11, 1919, p. 136.)

R

Anaphylactic Shock.

J. H. Lewis, Chicago (Journal A.M.A., February 1, 1919), has studied the subject of prevention of anaphylactic shock and reviews the literature that has appeared and the methods proposed. Friedberger and Mita have suggested the very slow administration of serum rather than the division of dose, and this suggestion is followed by Lewis in animal experiments. In the practice of serum treatment of pneumonia, certain questions arise. In the first place the concentration of anti-pneumonic serum has not been as successfully done as for diphtheria serum, and the use of large volumes of serum injected directly into the veins has been advised. Both of these facts are responsible for many unfortunate reactions reported. Lewis gives the results of experiments on dogs, rabbits and guinea-pigs. The results in the two former animals show that acute anaphylactic shock can be prevented by giving otherwise fatal doses to sensitized animals very slowly into the veins. The Woodyatt pump he finds excellent for the purpose, but the exact quantitative relations must be worked out experimentally. At present, it can only be said that the injections should be made as slowly and the dilutions as high as necessary under given conditions.

R

"Aspirin" a Common Name.

The claim of the Bayer Company to the exclusive right of applying the name "aspirin" to acetylsalicylic acid will be definitely set aside if the recommendation of the examiner of interferences of the United States patent office is upheld. The stand taken by the patent office is in line with the established principle that no one can have a monopoly in the name of any-

thing. Since "aspirin" has become the common name for acetylsalicylic acid, no one firm can have an exclusive right to it. (Jour. A.M.A., Jan. 11, 1919, p. 119.)

R

Coca-Cola.

Analyses made by federal chemists showed it to contain from 0.92 to 1.30 grains of caffeine to the fluid ounce. It would seem that in the interest of the public health the indiscriminate sale to children and adults of an alkaloid like caffeine in the enticing form of a "soft drink" is to be deprecated. (Jour. A.M.A., Jan. 25, 1919, p. 299.)

R

WANTED, FOR SALE, ETC.

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Infection of the Accessory Nasal Sinuses.

GEO. H. LITSINGER, M.D., Topeka, Kansas.

Read at the Annual Meeting of the Kansas Medical Society held at Kansas City, Kansas, May 1, 2 and 3, 1918.

In order to understand the subject of infections of the accessory nasal sinuses, we must have a clear conception of their anatomy and relations to other structures.

The sinuses are the air spaces occupying the bones adjacent to the nose and having their drainage into it. There are six paired sinuses, more or less regular in their size and location, together with the ethmoid cells, which are widely variable as to their number, size, and location.

The maxillary sinus, occupying the body of the superior maxilla, is the largest and most constant as to size and shape, however, all these air spaces are subject to the widest variation, and the antrum is no exception only as to infrequency of anomalous formation. Its roof, formed by the orbital plate of the superior maxilla, is a very thin plate of bone, and is in relation with the orbit. Toward the canine fossa the wall is usually quite thin. The roots of the bicuspids and first and second molars often indent its floor. Its nasal wall is membranous in part, the bony wall being absent in the middle meatus posterior to the unciform process and bulla as far back as the perpendicular plate of the palatal bone. The bony wall is usually very thin, lateral to the inferior turbinate. Well back in this membranous wall, lateral to the overhanging middle turbinate and at the end of the hiatus semilunaris, is to be found the osteum, situated at the

upper posterior angle of the sinus. It usually has a capacity of from 10 c.c. to 15 c.c., but may be much larger, and may be no larger than a lima bean.

The frontal sinuses occupy the space between the two plates of the frontal, superior to the orbits and nose. They are separated by a thin bony partition, which is constant, each emptying into the corresponding side of the nose, usually through the naso-frontal duct into the infundibulum, under the anterior overhang of the middle turbinate. These sinuses are subject to the widest variation as to symmetry, size, and shape. Often one sinus is very large and its fellow correspondingly small. They are often encroached upon by the ethmoid cells, occasionally one of the latter mounting well into the frontal space forming the so-called frontal bulla. At other times ethmoid cells almost completely double-deck the orbit. The frontals may mount high above the superciliary ridge and to the outer angle of the orbit, or they may be the size of a navy bean. Its posterior wall is formed by the thin underplate of the frontal and is in relation with the anterior fossa. Its floor is formed by the thin orbital plate of the frontal, being in relation with the orbit.

The sphenoid sinuses occupy the body of the sphenoid bone, separated by a thin septum, which is also constant. These sinuses are not subject to so wide a variation in size and shape. The roof is thin and is in close relation to the hypophysis, optic nerves and chiasm, brain, carotids, and cavernous sinus. The anterior wall is

thin, the osteum being situated in the upper portion near the septum.

The ethmoid labyrinth is subject to the widest vagaries of formation and is, hence, the most impossible of description. These cells, from eight to twelve on each side, seem to know but little limitation in their development. Supposedly confined to the two bodies of the ethmoid, they often push their way into the antrum, the frontal, and the sphenoid.

Suppose an elongated box, situated between the orbit and lateral nasal wall, from the lower border of the middle turbinate to the orbital plate of the frontal, forming the two sides; the inner border of the orbital plate of the frontal forming the roof and the upper surface of the body of the maxilla forming the floor, the sphenoid forming the posterior and the ascending process of the superior maxilla the anterior. Suppose this box having a number of partitions extending from side to side and from bottom to top, and you have a fair idea of the ethmoid labyrinth. The partitions are represented by the unciform process, bulla ethmoidalis, middle, superior and supreme turbinates.

The ostei of the greater number of these cells empty into the middle meatus, together with those of the frontal and antrum, and because of this common drainage under the middle turbinate, are classed as "Series One" or the "Anterior Series."

The ostei of the posterior ethmoid cells, usually two in number, open above the middle turbinate as do also the ostei of the sphenoid sinuses, and together are classed as "Series Two" or the "Posterior Series."

It is evident this classification is made because of the peculiarities in drainage. Series One drains under the middle turbinate; Series Two, above it. This knowledge is a great aid in diagnosis.

The ethmoid labyrinth is in relation externally with the orbit, superiorly with the floor of the anterior fossa, the optic and oculomotor nerves, and cavernous sinus. Thus it will be seen that each of the sinuses is in close relation with the orbit,

the optic, or oculomotor nerves of the eye. Dehiscences in these thin orbital walls make the orbital contents peculiarly liable to involvement during an infective process. The optic nerve is especially vulnerable because of its proximity to the ethmoid, sphenoid and frontal sinuses. Anastomoses of the ethmoid and ophthalmic venous systems make the contents of the globe subject to metastatic infections from sinusitis. Proximity of the frontals, ethmoids, and sphenoids, to the meninges and brain makes sinus infection a dangerous proposition.

The sinuses are outpocketings, so to speak, of the nasal mucosa, and hence their mucous membranes are similar histologically to the parent tissue, and react in the same general way to infections. By reason of the fact that their drainage systems are normally imperfect, namely; the ostei of the maxillary and sphenoid sinuses being situated at or about the highest part of their respective cavities, and the ostei of the frontal and ethmoidal cells being impinged upon by overlying or contiguous structures; by reason, to repeat, of their imperfect drainage, made worse or entirely occluded by Nature's reaction against inflammation, they become an easy prey to the acute infections of the upper respiratory tract and an empyema of one or more of them easily results.

Not alone is the drainage possibilities bad in the normal nose, but, by reason of the deformed septi, which seems the rule rather than the exception, the drainage is made very much worse, and the owners of such noses are prone to sinus infections. In some slides, which I shall show later, I hope to visualize this phase of the etiology, also to show more vividly the anatomy of the sinuses.

I do not pretend to know the physiology of the accessory sinuses. It may be interesting to theorize along that line, but I fear no profit would accrue from such a discussion, which is purely speculative.

The time of their development is interesting and important. The maxillary is present at birth, but it is only about the

size of a bean, and does not reach its full development until after the eruption of the permanent teeth—between the ages of fifteen and eighteen years. The frontal sinuses begin their development after birth and scarcely exist until after the sixth year. The ethmoid cells are present at birth, but reach their fuller development as the nose completes its form about puberty. The sphenoid is not present at birth and does not reach its full development until the fourteenth to sixteenth year.

ETIOLOGY.

Infection of the accessory sinuses of the nose is practically always secondary either to infections originating in the nose and pharynx, or from an extension of infections from dental origin. Formerly a large percentage of the cases were thought to originate from the teeth, but the consensus of opinion now is that not more than 20 to 25 per cent have such an origin. Syphilis and tuberculosis play a small part in the etiology, and scarcely deserve mention. Foreign bodies may be a cause, as also may trauma. As mentioned before, any marked deformity of the septum is a predisposing cause, as is also an enlarged middle turbinate, whether from hypertrophy or because it may contain an ethmoid cell, thus occluding the drainage from the frontal, antrum and anterior ethmoid cells. Infection may be secondary to malignancy or dentogenous cysts.

But the preponderating cause is the extension of an infectious process from the nose or throat. An acute coryza, influenza, nasal diphtheria, erysipelas, scarletina, measles, small pox, pneumonia, or other disease processes may, by extension, find way into the air spaces surrounding the nose and set up an acute infection. I think perhaps influenza is the most frequent cause of the cases seen here.

Once the mucosa of the nose falls a prey to infection of whatever nature, by contiguity of structure, the process may extend into the sinuses, and, as stated before, the tissues in reacting to the inflammation, interferes with drainage and tends to make it impossible for the cells to rid

themselves of the infectious material by their ciliated epithelium.

The pathology depends upon the nature and virulence of the infecting organism, the condition of the nose regarding deformities, the duration of the infection, and Nature's resistance.

THE SYMPTOM COMPLEX.

The two outstanding symptoms of sinus infection, either acute or chronic, are headache or pain and nasal discharge. The acute cases are usually easy of diagnosis by reason of these two practically ever-present symptoms, and even the chronic cases, while more subject to intermission of one or both of these two symptoms, have them as the real land-marks of the disease.

The headache differs even in infections of the same sinus, and differs in different attacks of the same sinus in the same individual, so that any definite classification of headaches with certain sinus infections is rather far-fetched. However, the pain of an antrum infection is apt to be localized over the antrum, or in the infra-orbital region; that of the frontal, supra-orbital; that of the ethmoid cells deep between the eyes; and of the sphenoid, in the vertex or occiput. The periodicity of pain probably corresponds to periods of occlusion of drainage; however, the pain of frontal disease seems to have no such relationship. This pain often begins at a certain hour in the morning, and, gaining momentum as the day advances, almost drives the patient to desperation, when, suddenly, and without increased drainage, it disappears, leaving the patient in comparative comfort. These are the sun pains of the laity.

The headache may be expansive or neuralgic, and is always intensified by stooping, jarring, straining as at stool, or when vomiting. It is intensified by alcoholic or other stimulants.

The discharge is unilateral, unless with a pan-sinusitis, or when sinuses are affected on both sides of the nose. The nature of the discharge depends, of course, upon the character and virulence of the

infecting organism, Nature's resistance, and the duration of the disease. Early it is serous, but soon may become blood-streaked and purulent, and finally mucopurulent and mucus. It is not stinking unless in long-standing cases, and then, when the pus is retained as in the antrum. In chronic cases it becomes catarrhal with exacerbations of purulent drainage. Don't forget that the antrum may be simply the cesspool of the sinus above it.

In acute cases there is usually elevation of temperature, increased pulse rate, and the symptoms generally of an acute infection, but the outstanding facts are headache and nasal discharge, coupled with the history of an acute rhinitis, either standing alone or as part of some acute infection.

The turbinates are periodically or constantly hypertrophied, interfering with drainage, nasal respiration, and often the sense of smell. Subjective odors, cacosmia, are often complained of. In the chronic cases the symptoms above enumerated are less constant. There is no temperature, no acceleration of the pulse, possibly only a morning accumulation of inspissated muco pus on the postpharyngeal wall, with occasional headaches usually coming on through the night. The patient may or may not confront you with headache or nasal discharge as his main complaint. His outstanding symptoms may be a lesion of the kidneys, stomach, eyes, joints, nervous and mental manifestations, or any of the many evidences of metastatic infection, or absorption of toxic products. In these cases the search must be painstaking to eliminate the possibilities of sinus infection. Symptoms may no longer stare you in the face. However, in the chronic cases a history of former acute attacks may be elicited, with headaches and more or less periodicity of unilateral discharge.

COMPLICATIONS.

The greatest immediate danger from sinus infection is extension of the process to the eye or brain. Orbital abscesses from frontal and ethmoid infections are

not uncommon and retrobulbar neuritis, metastatic infections within the globe, and toxic amblyopia, are to be feared. The sphenoid sinus also endangers the optic nerve.

The anastomosis of the sinus veins with the ophthalmic veins accounts for thrombosis of the cavernous sinus, the most hopeless of all complications. Subdural abscess, meningitis, and cerebral abscess may also follow empyema of the ethmoids, frontal, or sphenoid.

The most frequent complications of the latent or chronic cases are the more distant metastases. The work which has been done by such men as Rosenow and Billings in the last few years has shown conclusively that a very large number of conditions formerly classified as pathologic entities, such as the various arthritides, nephritides, gall bladder infections, appendicitis, gastric and duodenal ulcers, valvular heart lesions, infection of the interior of the eye, etc., are, barring the acute infectious diseases, practically always due to focal infections, and perhaps 15 to 20 per cent of such misnamed lesions take their origin from infections of the accessory nasal sinuses.

Many of the acute infections, such as diphtheria, epidemic meningitis, and acute anterior poliomyelitis, probably find their way into the blood stream through the defective mucosa of the nose or throat.

DIAGNOSIS.

The big trend in diagnosis is toward focal infection, and the accessory nasal sinuses must be taken into consideration. Except in cases of the frank, acute infections, no one now pretends to have his feet on solid rock who has not fully investigated the possibilities of the foci of the upper respiratory tract. The teeth, tonsils, sinuses, middle ear, and mastoid, taken collectively, are probably responsible for from 70 to 75 per cent of all focal lesions, metastases, from which come most of our chronic and many of our acute infections.

That the above statements are true—and they are vouched for by the best men

in the profession—makes the timely recognition and treatment of sinus infections of prime importance.

The diagnosis of sinus infection in general is usually easy, headache and nasal discharge being the usual outstanding symptoms. The chronic cases, of course, present the greatest difficulty. To individualize is the problem.

Given a case of unilateral nasal discharge, unaccounted for by any condition which in itself would account for the discharge, the question arises, in which sinus does it originate? Remembering that the anterior group of sinuses, namely: the frontal, anterior ethmoids, and antrum, empty their secretions under the middle turbinate, pus seen in that locality is fairly conclusive evidence that one or all of that series may be involved.

This examination presupposes shrinkage of the turbinate with cocaine, and possibly adrenalin, and good illumination by aid of a perforated head mirror, naso pharyngoscope, and post nasal mirror.

However, pus may not always be seen even with the history of profuse secretion. In that event the suction pump may bring the secretion into view. The patient may give a history of a morning post nasal accumulation only, or at irregular intervals, all of which would indicate involvement of either the antrum or sphenoid, because of their drainage peculiarities as before mentioned.

If the pus seen under the middle turbinate immediately reappears after having been mopped away, the presumptive evidence would be in favor of the frontal or anterior ethmoids; however, a full antrum might so drain from siphonage.

If the patient be lain with the affected side uppermost, an antrum with shrinkage of the lateral wall should drain out in an hour, so that on resuming the upright position drainage should cease.

A pledget of cotton inserted well back under the middle turbinate will occlude drainage from the antrum without interfering with frontal drainage. If, after such a pack, the drainage persists, the pus

is probably coming from either frontal or anterior ethmoids. Frontal tenderness, together with a shadow on transillumination, and the peculiar periodicity of headache, the sun pains of the laity, would spell frontal disease. An X-ray picture would cinch the diagnosis.

If, after packing, all drainage ceased, and transillumination showed a shadow over the affected antrum, with absence of crescent and pupillary illumination, the evidence would point strongly to the antrum. A needle puncture, made under the lower turbinate, would demonstrate conclusively the condition of the antrum as regards secretion. This procedure is so simple, so comparatively painless and harmless, so dependable, and so essential to treatment, that it stands as the sheet anchor in diagnosis. The X-ray picture, taken antero-posteriorly, shows obscuration of the affected side. It should also show obscuration if the ethmoids are involved.

Pus seen coming from above the middle turbinate, either through the olfactory fissure or posteriorly over the middle turbinate, into the choanæ, spells posterior sinus infection. The differentiation is extremely difficult.

The X-ray should be of greatest value; however, the interpretation of X-ray plates of the sphenoid sinuses and posterior ethmoids is not easy. In the picture these sinuses are so obscured by overlying shadows as to make it impossible to always place full dependence upon them.

The naso pharyngoscope, when one is able to get a view of the anterior wall of the sphenoid, gives dependable information, as it does in general, in viewing the interior of the nose.

Morning accumulations of thick, tenacious secretion in the nasopharynx, are suggestive of antrum infection and should call for a diagnostic puncture. Unilateral nasal polyps practically always indicate sinus infection.

TREATMENT.

The treatment in the acute cases should naturally be conservative and be directed to the procuring of the best drainage pos-

sible, with the least insult to the tissues. Copious irrigations with hot saline at two or three-hour intervals not only depletes the engorged tissues and washes away the accumulations, but by encouraging osmosis, pours Nature's antitoxic serum over the affected tissues and promotes resolution.

Divided doses of calomel, followed by salines, is indicated as in other infections. In the acute cases the patient should be ordered to bed with the usual light diet and given enough acetyl salicylic acid or other sedative to make him fairly restful. A watchful eye should be kept on the patient for any such complications as orbital or cerebral involvement.

Drainage may be further facilitated by making application of a 2 per cent cocaine solution with adrenalin to the lateral wall of the middle turbinate, or spraying the nose with one-half per cent cocaine with 1-5000 adrenalin.

After the acute stadium, more active measures may be taken to facilitate drainage, or whenever the symptoms indicate the time for more heroic treatment. The middle turbinate may be fractured toward the septum where space permits, or its anterior third or half may be removed.

The antrum should be punctured if evidence points to it as the offender. The anterior third of the lower turbinate should be removed if pus is found on aspiration, the opening enlarged, and the sinus irrigated.

All the chronic cases and many of the acute ones are surgical and cannot be discussed in this paper.

—————R—————

Chronic Peritonsillar Infections.

WM. LAPAT, M.D., Larned, Kansas.

Read at the Annual Meeting of the Kansas Medical Society held at Kansas City, Kansas, May 1, 2 and 3, 1918.

An acute peritonsillar abscess is, as you all know, a collection of pus between the capsule of the tonsil and the outer wall of the tonsillar fossa; it follows therefore that a chronic peritonsillar infection should be located in the same situation. We have, however, given the above title to our paper

not because of the exact situation of the infection but rather to emphasize the fact that it is as difficult in its diagnosis as the finding of pus in the very first stages of an acute peritonsillar abscess; literally speaking our paper would best be called "The Importance and the Method of Thoroughly Examining the Superior Tonsillar Fossa for the Foci of Some Infection."

In order that we may make our meaning more clear we will report two clinical cases and give a short resume of the most important anatomical points of the tonsil and its fossa.

The faucial tonsil situated in the sinus tonsillaris is a mass of lymphoid tissue. It has two surfaces, an internal and external; two borders, an anterior and posterior; two poles, a superior and inferior. The external surface, the posterior and anterior borders are covered by a strong thin membrane called the capsule which is developed within the mucous membrane of the posterior fossa wall and which is in reality a differentiated mucous membrane. The remaining parts are covered by epithelial tissue. There are ten to twenty crypts in each tonsil whose walls under normal conditions are in apposition and whose depths often go to the capsule; the upper crypts run downward and outward while the lower ones run outward. In diseased conditions these crypts are often filled up with debris which consists of epithelial cells, leucocytes, cholesterol granules, and various bacteria.

The fossa tonsillaris is made up by the anterior and posterior pillars consisting of muscular tissue covered by mucous membrane and reinforced by a reduplicated fold of mucous membrane, called the plica triangularis. This plica is attached to the superior border of the posterior pillar, the posterior edge of the anterior pillar, and is inserted into the lateral aspect of the base of the tongue. It varies in size, and when well developed acts as a sling for the lower pole of the tonsil and covers over some of the crypts. The superior part of the fossa is made up by the tissues of the soft palate which covers the upper pole

of the tonsil as a hood. In this situation we have also a small amount of lymphoid tissue which is continuous with but which is not a true tonsil tissue.

In looking for tonsil infection we thus have four important points to consider:

1. Tonsil crypts on the internal surface opening into throat.
2. Tonsil crypts on the anterior and posterior borders covered by plica.
3. Tonsil crypts in the superior pole covered by the hood of the palate.
4. Lymphoid tissue in the superior tonsil fossa.

As regards the crypts opening into the throat, the natural pressure of the pillars as they surround the tonsil will, in chewing and other throat movements, have a tendency to push to the surface any deep-seated debris, and in most cases a light, a head mirror and a tongue depressor will show us the existing condition.

As for the covered crypts on the anterior and posterior borders, the use of a probe will usually be sufficient to find the infectious material.

It is the crypts in the superior pole, aided and abetted by lymphoid tissue in the superior tonsil fossa, which are the ones mostly overlooked and to which special attention should be paid. In these the openings of the crypts are high and usually quite some distance back from the borders of the superior fossa. The infectious material works its way out and works further and further back into the crevices of the lymphoid tissue found in this situation. Ordinary and even extraordinary carefulness will often not allow its discovery, especially if it is small in quantity. We are well aware of the fact that minute quantities of pus will sometimes give rise to the most variable and complexing symptoms and conditions, and it is also true that the smaller the amount the more difficult is its localization.

The following two cases will, we hope, bring out more definitely what we mean:

1. I. C. F., male, single, aged 24 (Savannah, Georgia). Past history, negative. Present illness gave a very indefinite

history of various stomach and intestinal symptoms, which were all supposed to be caused by a chronically diseased appendix; this was removed without any apparent benefit and we were asked to investigate his nose and throat conditions. Our regular tongue depressor and probe examination showed a small and apparently normal tonsil but not being satisfied with this we injected into the superior angle of the fossa a quarter of one per cent cocaine, and then with a sharp separator opened for about a quarter of an inch at the angle where anterior and posterior pillar meet. We were amazed on putting the separator into the depths of the fossa to bring out its tip covered with debris. Both tonsils showed the same condition.

2. S. R., aged 9, white (Savannah, Ga.)

Referred to the Louis Porter Home Clinic, Savannah, for granular lids. As is usual, his throat was examined; the tonsils were small and we did not consider their removal necessary. His lids were curetted under a general anesthetic and because we had had at about that time two or three cases of so-called normal looking tonsils (as in the above), we decided to more thoroughly investigate his tonsils. Again we were surprised to find debris in the depths of the fossa.

Having had these and similar cases, we have made it a rule to divide our tonsils into two classes; those which show infectious material under the ordinary examination and those which do not; the latter we further investigate by injecting a quarter of one per cent cocaine into the superior angle of the fossa, separating for about half an inch the tonsil from its anterior pillar in this situation and going into the depths of the fossa with a dull curette; frequently we have brought out debris from a normal-appearing tonsil.

We may state in conclusion that this short paper with its short case reports was written to bring out only three important points:

1. To emphasize the fact that the most harmless and insignificant-appearing tonsil may be a bacteria incubator.

2. That in many cases it is absolutely essential to separate the pillars and go into the depths of the fossa to find this condition.

3. That the most satisfactory place to attack is the superior angle, *i. e.*, where the anterior and posterior pillars come to a point.

—————R—————

A Report of the Pathological Findings in Some Unusual Cases.

RALPH H. MAJOR, M.D., Rosedale, Kansas.
Clinical School of Medicine, Rosedale.

Read at the Annual Meeting of the Kansas Medical Society held at Kansas City, Kansas, May 1, 2 and 3, 1918.

During the past year in the School of Medicine, we have followed the scheme of presenting all cases which came to autopsy at a clinical pathological conference. This work has been carried on before classes of the third and fourth years and has been very instructive to both student and teacher.

I have selected five cases of rather unusual interest to bring before you this afternoon. They are all rather important specimens. The majority of the diagnoses are made clinically.

The first case we have to discuss is that of a woman sixty years old who came to the hospital to be treated for a growth on her face. It was a large fungating mass just below the eye, and had been present for the past seven or eight years. The surgeons made a diagnosis and waited for the patient to get stronger before operating on her. She made no complaint only that she felt a little fatigued, and she had very little appetite.

While they were waiting for the patient to gain in strength, she died suddenly. A remarkable condition found at autopsy showed the presence of an enormous tumor. A microscopic examination of this tumor showed it to be a typical round-cell tyroma.

Another interesting feature of the case was that the patient at no time had any definite gastric disturbance. There had been no stomach trouble symptoms whatsoever. Another feature was the presence of two separate and distinct malignant

tumors at the same time. This particular combination has not yet been reported.

The next case we are to review is that of a man aged 63, who entered the hospital complaining of a pain in the right side, which had began three weeks before. The possibility of a malignant growth in some part of the abdomen was thought to be possible. The man suddenly died and was prepared for autopsy. The interesting feature of this autopsy was the liver. As is shown in the specimen, there were scattered throughout the liver, curious soft places. We immediately suspected that this was one of the unusual liver tumors reported by some of the French. A microscopic examination of this tumor showed it to be of that class. This liver tumor is a very rare one. At Johns Hopkins, they had only three similar cases out of 3,700. This condition occurs about once in 1,000 autopsies.

The third case which I have to present is that of a woman aged 40, who came to the hospital complaining of backache, headache and stomach trouble. She also had been vomiting blood.

The most interesting physical finding in this case was the presence of a mass in the abdomen. This woman died unexpectedly before we had finished all of our test. The autopsy proved that she had the malignant disease which we had suspected. This was a case of the so-called "leather bottle stomach." Equally striking with the stomach condition was the condition found in both ovaries. Both were uniformly enlarged. This was then the bi-lateral tumor of the ovaries. The interesting feature of this tumor is the presence of a large cell containing a ring, and it is often called the "signet ring cell."

The next case is that of a man aged 34 who, when admitted to the hospital, had an enormous swelling of the abdomen. He had perfect health until he was 18 years old and the swelling began at that time and had gradually enlarged for 16 years. The physical examination was practically negative. The man showed evidence of chronic nephritis. For two years he was

under the observation of the hospital, with a constant enlarging of the abdomen. The patient finally died and was presented for autopsy. The autopsy proved that the man had an enormous liver. The patient weighed 90 pounds, and the liver weighed 50 pounds, so you see his liver constituted over one-half of the man's entire weight. Another condition the patient presented was that he had three distinct tumors.

The last case presented is a woman aged 20, who came to the hospital giving evidence of an acute abdominal condition. There were numerous ulcers in the intestines. Her trouble developed into acute peritonitis, and this caused her death. The ulceration in the intestine was probably due to hemorrhages.

—————R—————

New and Nonofficial Remedies.

Sulphoichthyolate Preparations.—Preparations containing as their essential constituents salts or compounds of a mixture of acids containing sulphur and designated by the group name "sulphoichthyolic acid" are manufactured from certain bituminous shales. Sulphoichthyolic acid is characterized by a high sulphur content, the sulphur existing largely in the form of sulphonates, sulphones and sulphides. The ammonium compound of this sulphoichthyolic acid—first introduced as ichthyol—has been used extensively. The current estimate of the therapeutic effects of sulphoichthyolate preparations is based almost entirely on the use of ichthyol. As it is not known to what constituent or constituents of ichthyol such effects as it may have are due, the actions of ichthyol cannot be transferred to similar preparations which differ from ichthyol in their composition. The use of sulphoichthyolate preparations is still largely empirical, and the evidence for their use unsatisfactory.

Ittiolo.—An ammonium sulphoichthyolate preparation manufactured from bituminous shales found in Giffoni Vallepiana, Italy. Its composition closely resembles that of ichthyol. Since ittiolo closely resembles that of the original ichthyol, it is claimed that its actions and uses

are also essentially those of ichthyol.—Giuseppe W. Guidi, New York.

Quinine Ethyl Carbonate-Merck.—First introduced as euquinine. It is almost insoluble in water, and is therefore practically tasteless. Its actions, uses and dosage are essentially those of ordinary quinine salts.—Merck & Co., New York (Jour. A. M. A., Feb. 1, 1919, p. 345).

Biologically Reactive Food Proteins.—The purified and concentrated proteins of foods. These protein products are used in cases in which persons show a peculiar hypersensitiveness or idiosyncrasy to certain articles of the dietary, both to determine to which food it is due and to immunize the patient against the effects of the food. The test for sensitiveness is made by scarifying the skin and rubbing in the protein to be tested, either dry or in solution. When the production of an urticarial wheal identifies the protein to which a patient is sensitive, the patient is desensitized by administration of gradually increasing amounts of the offending food or the isolated food protein itself.

Cow's Milk Allergens-Squibbs.—A powder representing all the soluble proteins obtained from cow's milk. It is a fine, white, odorless powder, somewhat soluble in water and physiological sodium chloride solution. Cow's milk allergens-Squibb has the actions and uses of biologically reactive food proteins.—E. R. Squibb & Sons, New York.

Egg Allergens-Squibb.—A powder representing all the soluble proteins contained in hens' eggs. It is a fine white powder, odorless, somewhat soluble in water and physiological sodium chloride solution. Egg allergens-Squibb has the actions and uses of biologically reactive food proteins.—E. R. Squibb & Sons, New York.

Wheat Allergens-Squibb.—A powder representing all the soluble proteins contained in wheat. It is a granular powder nearly white, odorless, somewhat soluble in water and in physiological sodium chloride solution. Wheat allergens-Squibb has the actions and uses of biologically reactive food proteins.—E. R. Squibb & Sons, New York (Jour. A. M. A., Feb. 22, 1919, p. 573).

THE JOURNAL

of The

Kansas Medical Society

W. E. McVEY, M.D. - - Editor

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The Annual Meeting.

In a few weeks the faithful will assemble at Ottawa for a few days, to hear and perhaps take part in the scientific discussion of many medical topics, to listen to the reminiscences of the soldier doctors from "over there," to meet and palaver with old friends and schoolmates, to enjoy the hospitality of a prosperous community—eat their food and smoke with them the pungent weed.

Let's all go. You doctors, who haven't attended a meeting in five years; and you who haven't attended one in *ten years*; and you who haven't attended one in fifteen or twenty years, come on down. Try to be young again, be gay and be happy.

You old fellows, who have been carrying the burden for the past year, come down and tell us something of that which your years of experience with the sick babies, sick women and sick men has taught you.

It is really too bad that there will be only two days of the meeting, but those two days will be so full of interest that you won't forget it for some time. We can't tell you about the program now—but it is good.

The Ottawa fellows say if that new hotel isn't finished in time and the other

hotels can't take care of us, they will just take us home with them and let us sleep on their own nice clean beds.

We might tell you more about it now, but we must save the best of it for the next number.

Come on down.

—R—

Our Constitution.

Casual perusal of our constitution will suggest the need for some revision, and in this issue we present some proposed amendments.

Article IV of the constitution provides for the composition of the society, but fails to include the officers and councilors, although delegates, members and guests are carefully defined.

The constitution does not provide for councilor districts and does not designate the number of such districts nor the counties that shall comprise them. It is probably true that the House of Delegates has at some time made such a division of the state. A laborious search of the proceedings of the past sixteen years will perhaps reveal that two such divisions have been made, but it does seem that such an important part of our organization should be carefully and explicitly stated in the constitution. In the proposed amendment, providing for the composition of the councilor districts, some rearrangement of component counties have been suggested. These changes seem advisable in order that in some of the districts at least the component counties may be grouped according to communicating railroad lines.

It has been customary to publish the list of counties comprising such districts in the annual program, but in the program for the meeting in 1918 neither Ellis County nor Rush County are included in any of the Councilor Districts; and in the Third District, "Iola" County is added.

By the reconstruction of the Councilor Districts as suggested the counties in the western part of the state may be more conveniently organized.

The further amendments proposed are simply such as are necessary to harmonize

other articles in the constitution with the changes that are proposed, but these are in the way of corrections. If the proposed amendment to the constitution providing for the councilor districts shall be adopted, the provision in Section 9 of Chapter IV of the by-laws for such division of the state becomes superfluous.

Section 3 of Chapter V of the by-laws provides that the treasurer shall render an account of the "state funds" in his hands. It should perhaps be "Society funds," but to eliminate the word "state" will leave the matter sufficiently clear and definite.

* * * * *

In looking over our by-laws we find several provisions that it might be well for the society to observe. In Section 5 of Chapter VII we observe the following: "As the finance committee it (the council) shall annually audit the account of the treasurer and secretary and other agents of the society, etc."

Section 1 of Chapter IX provides for three standing committees, a Committee on Scientific Work, a Committee on Public Policy and Legislation, and a Committee on Arrangements; and also provides that these shall be elected by the House of Delegates, unless otherwise provided. Section 4 provides that the "Committee on Arrangements shall be appointed by the component county society in which the annual session is to be held."

We have five standing committees, not including the Committee on Arrangements, and these are, according to custom, appointed by the president.

* * * * *

From time to time resolutions have been adopted for the government of the society in certain matters not provided in the constitution and by-laws. Such resolutions when adopted become Standing Rules and are binding on the society until they are rescinded or modified.

It was by such resolutions that three of our present standing committees were created and by authority of which they are appointed by the president.

Since such resolutions become standing rules for the government of the society, they should be collected and published as such in connection with the Constitution and By-Laws. Many of these resolutions should properly be adopted as amendments to the by-laws, but as standing rules they are quite as efficient, or would be if they were collected and published in a convenient form for reference.

* * * * *

A copy of the Constitution and By-Laws should be in the hands of every member of the society. In the present form it is not convenient to carry, nor is it indexed for ready reference.

It seems that it might be well worth while, after our constitution and by-laws have been carefully revised, to have the standing rules and important resolutions that have been adopted during the past sixteen years, collected and arranged and the whole carefully indexed and then published in convenient, pocket size edition.

* * * * *

When the state was originally districted, two councilors were elected for one year, four for two years, and four for three years. When the state was redistricted some years ago, and two councilors were added, these were elected for three years. The result is that in 1919 we will elect six councilors, in 1920 we will elect but two, and in 1921 we will elect four councilors. It is best for the interests of the society that men who have had experience in the council should be retained there as long as possible, and it might be of serious consequence if six new men were elected to the council in one year. Since councilors, according to the constitution, serve until their successors are elected, it might be a good plan to permit two of the councilors, whose terms expire this year, to serve another year without election. Four councilors will then be elected next year and four each succeeding year.

—————B—————

Proposals to Amend the Constitution.

Notice is hereby given, in accordance with Article XIV of the Constitution, of

certain proposals to amend the Constitution and By-Laws of the Kansas Medical Society.

It is proposed to amend Article IV to read as follows:

ARTICLE IV—COMPOSITION OF THE SOCIETY.

Section 1. The Society shall consist of officers, councilors, delegates, members and guests.

Sec. 2. The officers of this Society shall be a president, three vice presidents, a secretary and a treasurer, to be elected by the House of Delegates for such terms of office as hereinafter provided.

Sec. 3. The councilors shall be twelve in number, to be elected by the House of Delegates, one from each Councilor District, and to serve for such terms as hereinafter provided.

Sec. 4. Delegates shall be those members who are elected in accordance with this Constitution and By-Laws to represent their respective component societies in the House of Delegates of this Society.

Sec. 5. The members of this Society shall be the members of the component county medical societies or other societies approved by the Council.

Sec. 6. Any distinguished physician not a resident of this state, who is a member of his own State Society, may become a guest during any annual session on invitation of the officers of this Society, and shall be accorded the privilege of participating in all of the scientific work for that session.

It is proposed to add the following, which shall be Article V:

ARTICLE V—COUNCILOR DISTRICTS

There shall be twelve Councilor Districts, comprised as follows:

First District: Nemaha, Brown, Doniphan, Jackson, Atchison, Jefferson, Marshall, Pottawatomie and Riley counties.

Second District: Leavenworth, Wyandotte, Johnson, Douglas, Franklin, Miami, Coffey, Anderson and Linn counties.

Third District: Woodson, Allen, Bourbon, Wilson, Neosho, Crawford, Montgomery, Labette, Cherokee, Elk and Chautauqua counties.

Fourth District: Shawnee, Wabaunsee, Geary, Osage, Morris, Lyon and Chase counties.

Fifth District: Rice, McPherson, Marion, Harvey, Reno, Stafford, Pratt and Kiowa counties.

Sixth District: Kingman, Cowley, Sumner, Harper, Barber, Sedgwick, Butler, Greenwood, Clark and Comanche counties.

Seventh District: Rooks, Osborne, Jewell, Mitchell, Republic, Cloud, Washington and Clay counties.

Eighth District: Lincoln, Ellsworth, Ottawa, Saline and Dickinson counties.

Ninth District: Cheyenne, Rawlins, Decatur, Norton, Phillips, Smith, Sherman and Thomas counties.

Tenth District: Sheridan, Graham, Trego, Gove, Logan, Wallace, Ellis and Russell counties.

Eleventh District: Barton, Rush, Pawnee, Edwards, Hodgeman, Ness, Lane, Scott, Wichita and Greeley counties.

Twelfth District: Mead, Seward, Haskell, Stevens, Grant, Stanton, Morton, Ford, Gray, Finney, Kearney and Hamilton counties.

It is proposed to change the present Article V to Article VII.

It is proposed to amend Article VI to read as follows:

ARTICLE VI—COUNCIL.

The Council shall consist of the president, secretary and treasurer, ex-officio, and twelve councilors, one councilor to be elected by the House of Delegates from each Councilor District. Besides its duties as mentioned in the By-Laws the Council shall constitute the Finance Committee of the House of Delegates. Five Councilors shall constitute a quorum.

It is proposed to change the present Article VII to Article VIII, and proposed to change the present Article VIII to Article IX.

It is proposed to change the present Article IX to Article X, and amend it to read as follows:

ARTICLE X—TERMS OF OFFICE.

Section 1. The term of office of the president, vice-presidents and treasurer

shall be for one year. The term of office of the secretary and of the councilors shall be for three years. All of these officers shall serve until their successors are elected and installed.

Sec. 2. The officers of this Society shall be elected by the House of Delegates on the morning of the last day of the annual session, and no person shall be elected to any office who is not in attendance upon that annual session, and who has not been a member of the Society for the past two years.

It is proposed to change Section 4 of present Article IX to Article XI—Defense Board.

It is proposed to change present Articles X, XI, XII, XIII and XIV to Articles XII, XIII, XIV, XV and XVI respectively.

It is proposed to change Sec. 9, Chapter IV of the By-Laws by striking out the following: "Divide the state into Councilor Districts, specifying what counties each district shall include, and,"

It is proposed to change Section 3, Chapter VI, by striking out the word "state" in the last line.

—————R—————

National Medical Reciprocity.

In a recent number of "The Camouflage," a paper published at Camp Wheeler, Macon, Ga., an article appeared under the title, "An Appeal for National Medical Reciprocity." From this article we quote the following:

"In the interest of the morale of the medical officers who have been left in the service since the signing of the armistice, and as an act of simple justice to all medical men who have abandoned their work in civil life to serve in the army during the war, an effort should be made through the governors of the several states, or otherwise, to secure for the doctors who are graduates of reputable medical colleges and who have made good records, the right to practice in any state in the Union without examinations."

We are heartily in sympathy with this suggestion. We believe that every soldier

who fought in the great war, and every medical man who served in the hospitals or at the front should have every consideration and every benefit that can be given to an American citizen by his country. The privilege to practice medicine in any state in the Union is but a small favor for these medical officers to ask, and one that could be granted, no doubt, if the examining boards would themselves agree upon the plan. To eliminate a considerable amount of red tape, to sacrifice a little in the matter of fees, would solve the problem in a considerable number of states in which reciprocity relations have already been established. It is possible that the Federation of State Examining Boards will find a way to carry out the idea.

It is also to be hoped that what may be accomplished for the soldier doctors through sentiment may then be more generally applied for the benefit of the profession as a whole. As long as the regulation of the practice of medicine is regarded as a part of the police power delegated to each state, there is no hope for a national system of reciprocity, except through the harmonious co-operation of the state examining boards. In a majority of the states the laws are sufficiently uniform to justify a general reciprocity arrangement. The terms of reciprocity, however, should be more liberal than at present. If these terms cannot be made so elastic that a licensee from one state may be permitted to practice in all the other states, without securing a separate license in each, then there should be some plan by which the certificates from one state should be approved by the examining boards of other states, or at least those who have established reciprocity agreements. This is the principle upon which reciprocity is now practiced, but there is entirely too much red tape required and too much time consumed. Applications for license on a reciprocity basis must be acted upon by the board and, since they meet but two or three times a year, men often lose splendid opportunities for bettering

themselves while waiting for the determination of the board. The matter could be much simplified and made of much more practical value if the boards which have agreed upon a standard of qualifications would file with each other definite memoranda of the data concerning the licensing of each candidate. These data could then be considered and approved by each board and its secretary authorized to issue licenses on application.

The government seemed to find the credentials of licentiates from the various states a sufficient guaranty of their ability to care for its sick and wounded soldiers. No technical examinations were required and yet there is no evidence that there was any inefficiency in the medical department of the army. In fact, the proposition is generally true that examining boards do not devise an examination for the purpose of determining the candidate's knowledge of medicine, but for the purpose of providing a convenient and simple method for eliminating undesirables.

There should be some more liberal provision in these reciprocity agreements for the men, graduates from reputable medical colleges, who were admitted to practice before the examination requirements went into effect in many states. In this class will be found some of the most successful practitioners in every state. Sometimes a man in this class, for some very excellent reason, desires to change his location, but finds that in spite of an enviable professional reputation in his own state, in spite of long years of study and great experience, he is unable to meet the technical requirements of the board of examiners of the state in which he desires to practice. Instances of this kind not infrequently occur. Our medical practice laws are presumably for the purpose of protecting the public against incompetent doctors, but it is absurd to presume that any community or any state would be injured by admitting to the practice of medicine these men who have proven their knowledge and skill in other states.

The following is the committee on arrangements for the annual meeting to be held at Ottawa, May 7 and 8: Dr. F. C. Herr, chairman; Drs. H. L. Kennedy, W. L. Jacobs, H. W. Gilley, C. W. Hardy, J. P. Blunk, J. B. Davis, G. W. Davis, E. B. Gossett, R. C. Dugan and V. E. Lawrence.

—R—

A Tribute to Dr. S. G. Stewart.

Dr. Stewart is dead. He had made good in his generation. He did his duty as he saw it. He had a pleasing personality. He was an optimist. He was always cheerful. He was faithful to his friends. He was a forceful character. He never tired. He was a model citizen. He was on the right side of every moral question. His conduct squared with his profession. He was a patriot and a brave man. He was a faithful physician. He began trying to and did help to make life worth living; not for himself alone, but for the down-trodden, the slave.

He reared a family and inspired them with the love of patriotism and liberty and a love for the cause of justice and humanity. His life and example have borne fruit, and his three sons offered themselves to their country in her time of distress and they are serving in the great world war for the right. If he had had more sons living no one questions but what they too would have put on the armor and battled for the oppressed.

Such a spirit, life and example was Dr. Stewart. Such a spirit never dies; never is lost. But in the long vista of time it continues to multiply, increase and gain force until the whole human family is filled with the fatherhood of God and the brotherhood of man. J. E. MINNEY.

—R—

DEATHS.

E. L. Uhl, M.D., Baldwin, Kansas, aged 34 years, a graduate of Rush Medical College, 1911, died at his home in Baldwin on February 10, after an illness of fourteen months duration. He was a member of the Kansas Medical Society and of the American Medical Association.

Excerpts—By The Prodigal.

It is well known that the digestive secretions are furnished in proportion to the palatability of the food. Also that the appearance and the odor of the food have to do with the flow of the digestive juices. How important then in the treatment of faulty digestion is the preparation and serving of the food. A doctor should be a good connoisseur in order to be a brilliant success in the practice of dietetics.

PSYCHIC JUICE.

Pleasurable emotions favor the flow of the digestive secretions and hence of digestion and thus of the reparative, building up and growth process of the body which means a restoration of the sick or injured to health.

The doctor's personality also has to do in making the sick man well. A sickly, grouchy, acid-natured doctor has no place in the practice of medicine. All of which leads to Cannon's conclusion "That just as there is a psychic secretion, so there is probably a psychic tone or psychic contraction of the gastrointestinal muscles, as a result of taking food."

AND

"How one thing brings up another," as remarked by the fellow who had taken an emetic. It was Henry Ward Beecher who said that "A dyspeptic could not enter the Kingdom of Heaven."

S. O. S.

The Treasury Department of the United States Public Health Service has sent out an S. O. S. pamphlet or Bulletin, No. 24, headed—

**"War on Venereal Diseases to Continue.
Country Must Be Kept Clean."**

This pamphlet contains an extract, telegram and statement from McAdoo, Baker and Daniels, respective heads of Treasury, War and Navy departments, urging upon communities, states and the people as a whole to help in the good work and the evangelization of themselves—the people—in keeping clean and freeing man so far

as possible from gonorrhea and syphilis and all other diseases; but placing the emphasis on the venereal danger.

"What the War Taught" is capitalized and under the above heading it goes on to say, "Before the war most physicians and public health officers knew that gonorrhea was every year causing thousands of cases of blindness among infants, countless surgical operations on women, and sterility in both men and women; that syphilis was being transmitted to offspring causing physical and mental defectives, that it is a prolific cause of locomotor ataxia, paresis or softening of the brain, insanity, miscarriages, diseases of the heart, blood vessels and other vital organs. But people generally did not know these things and few remedial measures were taken. The war opened our eyes. The reports of draft boards and camp surgeons revealed for the first time, clearly, the menacing seriousness of the venereal problem and the failure of our pre-war attitude toward the whole question."

The warning is commendable if long delayed. It is almost a generation ago since the American Medical Association appointed a committee to prepare ways and means to meet this very condition which exists today; to warn and educate the people against the great danger of the spread of venereal diseases and of the terrible toll of life it was taking and the suffering brought on by gonorrhea and syphilis. Attention is called to the action taken by the government, not for the purpose of criticism or censure, but to commend the effort and as a further proof that "the advance in medicine marks the progress of civilization." Civilization being an advanced state of material and social well being—it not only took a long and persistent effort and education by the medical profession "to open our eyes and to show up the failure of our pre-war attitude to the whole question," but a world catastrophe—a bloody war to get the officials of government and the laity to sit up and take notice. The leaven is now at work and the medical man must not let up on

the pressure, but continue the fight for an advanced civilization. This myopic condition of the people in not "opening their eyes" to the danger of these venereal diseases and to all preventable diseases, shows how lopsided so-called civilization is. And how slow in emancipating itself from ease-loving and lust, and to follow the lines of least resistance. "No knowledge is *our* knowledge until we have lived it."

The danger of specialism is that it gives organic precedence to that of systemic.

The reflex specialist is due.

Where will the physician—had to be polished off in Germany—go now to get his peacock finish?

The examinations of drafters showed that five men came into the army with venereal disease to every one who contracted it after he was in the army.

And now it's endocrinology and its corollary, organotherapy.

CHEER UP, BROTHER.

If you cannot write a long dissertation on some unpronounceably-named disease, but can swat the entity that causes the trouble, you can train with the gang.

John Stewart Mill said that every great movement must experience three states, viz.: ridicule, discussion and adoption. This is true with emphasis in the new discoveries in medicine.

ASEPSIS AND TECHNIQUE.

In every surgical operation there should be scrupulous cleanliness observed and the technique should be the best. In other words, the part to be operated on as well as the patient should be clean and the operation should be done in a common sense and skillful manner.

But at times it would appear that an effort is being made to overdo common sense requirements and to lay one over on

Nature and circumvent or corral the impossible. The preparation and effort being in keeping with the reason given why a man has rudimentary mammary glands. That in case Nature should ever make a bauble or by some hokus pokus or feat of legerdemain a man *should* have a baby, the glands would be there to nurse the baby.

—————R—————

Joint Influenza Committee.

Word comes from Washington that a joint influenza committee has just been created to study the epidemic and to make comparable, so far as possible, the influenza data gathered by the government departments. The members of this committee, as designated by the surgeon general of the army, the surgeon general of the navy, the surgeon general of the public health service, and the director of the census, are: Dr. William H. Davis, chairman, and Mr. C. S. Sloane, representing the bureau of the census; Dr. Wade H. Frost and Mr. Edgar Sydenstricker, of the public health service; Col. D. C. Howard, Col. F. F. Russell and Lieut. Col. A. G. Love, United States army; Lieut. Com. J. R. Phelps and Surgeon Carroll Fox, United States navy.

—————R—————

SOCIETY NOTES.

FRANKLIN COUNTY MEDICAL SOCIETY.

Dr. R. C. Dugan is in Rochester, Minn., receiving treatment from the Drs. Mayo Hospital.

Dr. A. Haggart, formerly of Ottawa and who moved to Tonganoxie, Kansas, last June, has recently located in Elgin, Kansas.

Mrs. Lawrence, wife of Dr. V. E. Lawrence, has been confined to her home for the past month.

The members of the Franklin County Medical Society are making plans and arrangements to entertain the members of the Kansas State Medical Society, who hold there convention here in Ottawa on May 7-8. Ottawa has the Nelson Hotel with 48 rooms, the March House with 50 rooms,

and the Tavern with 30 rooms. The new North American Hotel with 58 rooms is supposed to be completed before the convention. This hotel would have been completed by January 1, had the contractors been able to secure material. The hotel will be five stories high, modern and fire-proof.

The Franklin County Medical Society met in their fourteenth annual banquet January 29. The doctors and their wives make this an annual event and this year's banquet was a decided success with Dr. V. E. Lawrence as toastmaster. The address of Hon. W. S. Jenks on the New Map of Europe showed much thought and study of the war situation in Europe. All present enjoyed the address.

Harold D. Kennedy, son of Dr. K. L. Kennedy, was wounded at the battle of the Argonne Forest. He is a member of the 35th Division.

Dr. George Mahaffy, who is a member of the Franklin County Medical Society, is located at Camp Grant, Illinois.

H. L. KENNEDY, Sec'y-Treasurer.

HARPER COUNTY MEDICAL SOCIETY.

The Harper County Medical Society met in the Commercial Club rooms at Anthony, Kansas, March 19, at 2 p. m. The president, Dr. Montzingo, of Attica, called the meeting to order. The following program was rendered:

Paper, Bone Abscesses, by Dr. Gaume, Harper.

Paper, Placenta Previa, by Dr. Montzingo, Attica.

Paper, Influenza and Complications, by Dr. Galloway, Anthony.

Paper, Medical Advances in Obstetrics, Dr. Trekell, Harper.

Paper, Gleanings from Military Life, Dr. Cronk, Anthony.

Paper, Actinic Light in Treatment of Skin Diseases, Dr. Walker.

A. E. WALKER, Secretary.

NEOSHO COUNTY MEDICAL SOCIETY.

The Neosho County Medical Society met at the Johnson Hospital, Chanute, Kansas,

February 25, 1919. Members present: Drs. Light, Steele, Ashley, of Earlton; Royster, E. A. Davis, Baird, Mathis, A. M. Davis, B. I. Johnson, L. D. Johnson, Follett, Garton.

After the banquet in the dining room of the hospital, the following officers were elected for the ensuing year: President, Dr. E. A. Davis; vice president, Dr. S. G. Ashley, Earlton, Kansas; secretary-treasurer, Dr. W. K. Mathis; censor, Dr. L. D. Johnson; delegate, Dr. P. Follett; alternate, Dr. E. A. Davis.

Mr. W. E. Burns, bacteriologist, who has recently located here, gave a very interesting talk along his line of work, after which the Society elected him an honorary member.

BOOKS.

Neoplastic Diseases.

A text-book on tumors, by James Ewing, M.D., Sc.D., professor of pathology at Cornell University Medical College, New York City. Octavo of 1,027 pages with 479 illustrations. Philadelphia and London: W. B. Saunders Company, 1919. Cloth, \$10 net.

Ewing has presented us with a most comprehensive work on neoplastic diseases. He has endeavored to introduce a classification of tumors depending upon their histogenesis and structure and to analyze the numerous etiologic factors involved in their production. He has also presented from the pathologist's point of view the striking clinical features of the different tumors and the relations between their clinical course and histologic structure.

In his definition of what constitutes malignancy a rather broad view is held. He says: "The tendency is to restrict the term to tumors which exhibit certain features which are extremely deleterious to the host. The most important of these features are infiltrative growth, local destructive properties, recurrence after removal, formation of metastases, local interference with function and general toxic action of absorbed tumor products."

The volume is well illustrated and practically all of the plates are made from photographs.

Principles and Practice of Obstetrics.

By Joseph B. DeLee, A.M., M.D., professor of obstetrics at the Northwestern University Medical School. Third edition, thoroughly revised. Large octavo of 1,089 pages with 949 illustrations, 187 of them in colors. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, \$8.50 net.

Although but a short time has elapsed since the appearance of the second edition of DeLee, a copy of the third edition is now before us. It has been subjected to a considerable revision, some chapters having been largely rewritten, and many subjects of practical interest and value have been much enlarged upon. Considerable new material has been added to the subjects of obstetric anesthesia and analgesia, perineorrhaphy, cesarean section, and the treatment of contracted pelvis. Rectal examination has been given more important recognition in the chapter on the conduct of labor. The illustrations are abundant and remarkably instructive. They have not been omitted in any place where they might aid the student in understanding the text.

Pathological Technique.

A practical manual for workers in pathologic histology and bacteriology, including directions for the performance of autopsies and for clinical diagnosis by laboratory methods. By F. B. Mallory, M.D., associate professor of pathology, Harvard Medical School, and J. B. Wright, M.D., pathologist to the Massachusetts General Hospital. Seventh edition, revised and enlarged. Octavo of 555 pages with 181 illustrations. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, \$3.75.

The seventh edition of Mallory and Wright's Pathological Technique has been received. It has been revised and reorganized. Some new material has also been added. Several of the more recently devised staining methods have been included as well as several developments in laboratory technique. A laboratory without a copy of this book is certainly incomplete.

Essentials of Pharmacy.

By E. L. Sayre, Ph.G., Ph.M., dean of the School of Pharmacy, University of Kansas, and professor of pharmacy and materia medica, and L. D. Havenhill, Ph.C., Phar.M., professor of pharmaceutical chemistry in the School of Pharmacy of the University of Kansas. 12-mo of 495 pages. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, \$2.75 net.

The authors of this textbook need no introduction to medical men in Kansas.

The name of Sayre is so intimately associated with the pharmacy of the West that whatever comes from his pen will be regarded as authoritative. A wonderful amount of information on the subject has been condensed into a small space but so presented that it is readily assimilated.

A Manual of Gynecology.

By John Cooke Hirst, M.D., associate in gynecology, University of Pennsylvania; obstetrician and gynecologist to the Philadelphia General Hospital. 12 mo of 466 pages with 175 illustrations. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, \$2.50 net.

The author's purpose in preparing this book was apparently to reproduce in some permanent form the material which he has given to his students for many years. On the whole it is a very concise and quite accurate outline of the subject of gynecology. Much has been gained in the method of presentation, so that in many chapters of the book a great many important facts have been stated in few words. The subject seems to have been thoroughly covered and should be a very convenient reference book for the practitioner as well as the student.

A Manual of Diseases of the Nose, Throat and Ear.

By E. B. Gleason, M.D., professor of otology in the Medico-Chirurgical College Graduate School, University of Pennsylvania. Fourth edition, thoroughly revised. 12-mo of 616 pages, 212 illustrations. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, \$3 net.

Gleason's manual has again been revised and for the purpose for which it is intended is very well adapted. It is a convenient little reference book in which the practitioner will find quite concise descriptions of the various diseases of the nose, throat and ear, and very explicit directions for their treatment. We have observed a few changes in the third edition, some additions that add materially to its value, and some eliminations of material that could well be omitted.

—R—

The contractors have promised the Ottawa physicians that the new American Hotel now being erected in that city will be completed in time for the annual meeting of the State Society.

High Prices Cause Record Low Profits.

Armour & Company's financial statement issued recently states that food prices were so burdensome during the past fiscal year that profit margins were almost wiped out and despite a record volume of business—\$861,000,000 in this country and for export—earnings were much less than the sum fixed by the Food Administration as being fair and proper.

The net income for the year was \$15,416,973.13, representing a return of 14.7 per cent on common stock after making provision for dividends on preferred stock. Excepting \$2,000,000 which constituted the dividend paid to common stockholders, the year's earnings were reinvested in the business.

On the average net capital invested in all lines, the profits represented a return of 9 per cent. The income from the meat food business—limited by the government to 9 per cent—fell way below that figure to about half what was authorized. The net profit on total volume of business including everything sold by the firm, amounted to 1.8 cents on each dollar of sales.

In explanation of high prices, Mr. Armour stated that his firm paid out to live stock producers \$100,000,000 more than the same weight would have cost in 1917.

—————R—————

A New Bulk Bacterin Container.

A doctor who uses bacterins in quantity will be interested in a new form of bulk container which has been perfected, holding a considerable quantity of the bacterin, 5 mil. or 20 mil., and so arranged that any desired quantity of its contents may be withdrawn without danger of contaminating the rest. Various types have appeared, the chief objection to them all being that the perforable cork could be, and was, easily worked loose in frequent handling. This danger is at last eliminated in the excellent container recently announced by the Abbott Laboratories, of Chicago, Ill. The perforable rubber diaphragm is incorporated into the rubber cork, which is in-

serted tightly into the neck of the bottle. Over this is placed a metal cap, with a single opening through which the needle may be inserted, sealing automatically upon withdrawal, and this cap is then crimped down around the collar of the bottle. It is impossible for it to work loose and would present quite a problem if you were to try to remove it intentionally. Thus is the original sterility of the contents permanently assured. Over all is placed another metal cap, nicely machined so that it fits snugly and presents a pleasing appearance, besides adding further protection.

This container is of a squat style so that it will not easily tip over—just another evidence of the painstaking care and minute attention to detail which characterizes its entire construction. The bacterins which the Abbott Laboratories supply in these 5 and 20 mil. containers are well known for their purity, sterility, and accuracy. A complete list will gladly be sent upon request.

—————R—————

Chlorazene in Genito-Urinary Cases.

Dr. E. Styles Potter, visiting surgeon of the West Side Hospital, Genito-Urinary department, New York City, has the following to say of irrigation in the treatment of urethritis:

"Irrigation has long been known to be a useful method of applying locally the various remedies that have from time to time been considered favorably in the treatment of the simple and septic varieties of urethritis. After an experience extending over many years and thousands of cases and including the use of permanganate of potash, hydrargyrum bichloride, boric acid, carbolic acid, protogol, argyrol, tr. iron chloride, infusion of common drinking tea, zinc chloride, normal saline solution, etc., I now wish to call attention to the fact that paratoluene-sodium-sulphochloramide (Chlorazene) used as an irrigation remedy seems to possess most unusual curative effects. It has the advantage of not being irritating, is evidently a powerful germicide and appears to have

a slight astringent effect as well. I have been using this remedy in acute simple and septic anterior urethritis for some months and really the results obtained have led me to regard it as a very satisfactory remedy in the treatment of these conditions.

"I have come to regard Chlorazene superior to permanganate, protogol, or other irrigating solutions in general use, and now use it exclusively."

————— R —————

The Use of Yeast in Gastroenteritis.

Among the diseases in which yeast was used successfully by Hawk and his co-workers (*Journal A. M. A.*, LXIX, Oct. 13, 1917, pp. 1243-1247) is gastro-intestinal catarrh. This was rather to be expected since brewers' yeast was early used with success in various diseases of the gastro-intestinal tract. The value of Hawk's article is that he showed that the unavailable brewers' yeast may be replaced by the uniform and readily obtainable compressed yeast.

Among the diseases in which various forms of yeast have been used with success is gastroenteritis of infants. There is every reason to believe that these will react to compressed yeast at least as readily as they did to yeast in other forms. Aside from its freshness, as in the cake supplied by the Fleischmann Company, compressed yeast may be readily gauged as to dose, in itself possesses nutritive properties and contains vitamins. Autolyzed yeast when given by Hess to babies produced a rise in the weight curve. (*Am. J. Dis. Children*, Vol. XIII, No. 1, Jan., 1917, pp. 98-109.)

Yeast was used in the treatment of gastroenteritis of adults and infants by Drs. Thiercelin and Chevreu (*Rev. de therap. med.-che.* 1899, pp. 797-803) with marked beneficial results. They gave a suspension of yeast to children by rectum, two or three times a day after the rectum had been washed out. The children were held by the nurse in such a position that they could not expel the sus-

pension. Food was withheld until the fever fell.

Cases of chronic gastroenteritis were treated the same way. In one case of dysenteric diarrhea (in an adult) that had resisted other treatment for more than a month, the remedy was used with success within forty-eight hours after first administration. The adult cases were given yeast by mouth as well as by rectum. (One case in an adult was a case of muco-membranous enteritis, which improved very much under yeast treatment.)

It stands to reason that yeast will exert a greater influence on the gastro-intestinal tract when it is given by mouth than when it is given by rectum alone. Yeast also has a beneficial effect on infants with gastroenteritis when it is given by mouth. This is shown to advantage in the results obtained by Sittler in the treatment of infants with gastroenteritis with yeast by mouth. (*Munch. med. Woehenschrift*, 1906, No. 36, pp. 1761-1762.) Sittler's plan was to cut out milk from the diet, to substitute weak tea or albumin water and gradually to work up to heavier preparations. The yeast was given in sweetened water. When necessary the bowels and the stomach were irrigated and other medicines were employed. Under yeast treatment the odor of the stools became less objectionable, and the number of stools was diminished. Vomiting soon ceased. In some cases a cure was obtained when yeast alone was used. In other cases yeast had a beneficial effect when calomel, bismuth, or irrigation had not produced satisfactory results. The weakly acid reaction of the stools favors the action of the yeast. In one case only did the diarrhea become worse under yeast treatment. The treatment can be satisfactorily combined with the administration of bismuth or tannalbin.

In a more recent publication Sittler investigating the stools of infants has determined that yeast with lactic acid and lactic acid bacilli favors the growth of the *bacillus bifidus* (a favorable organism) in the stools. He states that treatment with yeast, lactic acid, and lactic acid bacilli

may be combined to advantage with treatment with the astringents.

—————R—————

Enuresis in Adults.

Enuresis in children has an extensive literature, but little can be found in textbooks or elsewhere on its occurrence after childhood. When, therefore, it is found in adults in military life it is naturally attributed to malingering and treated as such, at least experimentally. Heiman Caro (Chelsea, Mass.), Fort Snelling, Minn. (Journal A. M. A., Feb. 15, 1919), presents an analysis of twenty-five case histories of idiopathic enuresis observed at Camp McClellan, Ala., the subjects being all between 17 and 38 years of age, the majority under 25. Twenty-one gave a history of existence of the condition since childhood. The other four showed various histories of injuries, etc. Thirteen of them gave a family history of similar conditions. All of them were heavy, deep sleepers, and there were among them distinct trends toward the vagotonic constitution, and in only one toward a sympathetico-tonic. Facial asymmetries were noted in thirteen, while other abnormalities were usually also present. Neurologic examinations showed increased deep tendon reflexes, while the faucial ones were usually subnormal. Urinalysis was negative, except in one case of cystitis. Cystoscopy in eight cases gave normal findings, except for increased resistance to the catheter at the compressor urethral muscle. Psychometric tests were completed in all cases. The Yerkes-Bridges point scale, with a total of 100 points, was used, and the results are shown in a table, giving a somewhat low grade in thirteen of the patients. "The usual defects were found to be in memory span, logical reasoning, judgment and in acuity of insight. All the men had worked steadily at various occupations of a manual character when in civil life. None showed any criminal or other psychopathic trends. But the noticeable feature was their blase manner, almost amounting to indifference, with which they discussed their ailment. Their attitude can be

summed up best in their common answer, 'I can't help it.' Summary of Clinical Data: The factors here presented may be summarized under four headings: (1) a family history of neuropathic or cardio-renal disease; (2) a history of nocturnal enuresis, existing since childhood, with periods of remission, and always accompanied by imperative urination and by deep sleep; (3) disclosure on physical examination of vagotonic trends, with negative neurologic and urologic findings; (4) all associated with certain border line defects in mental efficiency." The constant feature of these cases was a lack of gross pathologic findings. As regards etiology, the lack of character formation must be considered, and the author concludes that nocturnal enuresis in adults is a distinct clinical entity, resistant to ordinary psychotherapeutic measures. The etiology is obscure, but the theory of inherited organ inferiority is applicable.

—————R—————

Influenzal Pneumonia.

W. J. Stone (Toledo, Ohio) and G. W. Swift (Cleveland, Ohio), Fort Riley, Kan. (Jour. A. M. A., Feb. 15, 1919), report their observations of influenza and pneumonia at Fort Riley, Kansas. The total military population was 63,374, in whom occurred 15,170 cases of influenza, 17.2 per cent of these passing into pneumonia. Among the 2,604 pneumonia patients 941 deaths occurred in forty-one days, a mortality of 35.8 per cent. The final clinical diagnosis of the fatal cases were: lobar pneumonia, 72.6 per cent; bronchopneumonia, 23.8 per cent. In fifty-five necropsies the diagnosis of combined lobar pneumonia and bronchopneumonia was made in 72.6 per cent, and bronchopneumonia, 27.2 per cent. In the sputum cultures from a total of 928 patients, B. Influenzæ occurred singly or in combination in 18.7 per cent, and in seventy-seven fatal instances it was found in the sputum cultures in 5.2 per cent. At necropsy, in fifty-five instances, cultures from the lungs, heart's blood, sinuses, pleural fluids, etc., showed pneumococcus in 56.1 per cent, and strepto-

coccus hemolyticus in 41.1 per cent. This last organism was also isolated in 41.5 per cent of sixty-five resulting empyemas. No deaths occurred except from pneumonia or its complications, though a hemolytic streptococcus was responsible for death in the majority of instances; interstitial pneumonia was not a prominent feature, but if it occurred early, in three or four days, it made up the pathologic picture. This was especially true after pneumonia following measles, but when it occurred later in the epidemic entire lobes of the lung had been involved. The same organisms invaded the brain, meninges, sinuses, etc. Subacute vascular meningitis with edema was a striking feature in 58 per cent of forty-eight necropsies, while brain edema without meningitis was present in 21.9 per cent of the cases. Otitis media, mastoiditis, phenoiditis, and ethmoiditis were present in varying percentages. Bone necrosis of the mastoid was rare as compared with its occurrence in otitis media from scarlet fever, measles or tonsillitis. The author's conclusions are that, from the facts known, it appears that B. influenzæ or an unknown associated virus is a responsible invasive feature of the epidemic of acute respiratory disease, but as a cause of death the pneumococcus and associated hemolytic streptococcus were largely responsible. They believe that the pneumococcus pneumonia, without the hemolytic streptococcus associated, has a relatively low mortality. Generalized systemic invasion by the combined infections occurred in many cases, and they recommend for diagnosis the use of cultures of hemolytic streptococcus from the tonsil crypts or surfaces on blood-agar plates. Otitis media, when it occurred, was always accompanied with mastoiditis, and drainage of the middle ear should be promptly secured. A dull occipital headache suggests sphenoid sinusitis, and shrinking of the nasal mucosa by spraying with 4 per cent aqueous antipyrin solution gives relief. Lumbar drainage in delirious pneumonia patients not only helps diagnosis but is a useful therapeutic measure and is advised to be repeated if necessary.

Tincture of digitalis, standardized to definite dosage, and administered to the full estimated requirement during the first twenty-four to thirty hours in pneumonia, has seemed to lessen the mortality. The most common complications of the influenzal pneumonia were: pleural effusions, empyema, pericarditis, cerebral edema and meningitis, otitis media and the various sinusitis types, and nephritis. Specific pneumococcus antisera supplementing Cole's Type I are very desirable, but more attention should be paid to the part played by the hemolytic streptococcus in causing these pneumonias. Not much can be expected from the treatment of pneumonias due to this organism until a potent antiserum has been produced. Many polyvalent serums are on the market, but opinion is not unanimous as to their value.

—————R—————

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—————R—————

Scilla Is a Useful Heart Tonic.

Mendel (Die Therapie der Gegenwart, April, 1918) points out that scilla improves the pulmonary circulation and causes a better blood supply to the mucosa. Thus, in emphysema it brings about a decrease of the catarrh although the drug cannot be said to possess any directly expectorant property. Given in therapeutic doses it is impossible to discover any action of the drug on the kidney or the renal functions, so that one may exclude any changes taking place in the renal tubes or glomerula from its exhibition. The combination of scilla and codeine phosphate has been found very active and useful. In order to obtain satisfactory results the drug should be given in diuretic doses which must be adapted to each individual. One will frequently be obliged to carry out an intermittent treatment. In therapeutic doses scilla has no nefarious sec-

ondary effects and there is no danger of accumulation of the drug. It lends itself to both continued and interrupted medication, leaving no harmful effects.—N. Y. Med. Jour.

—R—

Benzyl Alcohol.

While experience alone will tell whether or not the local anesthetic benzyl alcohol of phenohethylol will come up to the expectations of the discoverer of its action, it was deemed of sufficient promise by the Council on Pharmacy and Chemistry to warrant its admission to New and Non-official Remedies. (Jour. A. M. A., Feb. 22, 1919, p. 594.)

—R—

Reconstruction of the Uterus.

Dr. Charles R. Robins, of Richmond, Va., approached the subject from two points of view, first the obvious advantages of exploring the cavity of the uterus through a direct incision. In this way many cases could be relieved without resorting to the radical measure of removing the uterus. From the other viewpoint the consideration was the removal of the pathological portion of the uterus and its reconstruction from the portions left. This procedure was facilitated by the anatomy of the organ. The blood supply and the tubes entering from the sides made it possible to remove as much of the intervening portion as might be necessary. The only thing necessary to leave was a continuous cavity from the tubes to the external os. This operation could most frequently be practiced in the treatment of fibroids. It was not intended that it should be generally used because the cases in which it was indicated or possible were comparatively few. However, in young unmarried women and in married women who had not borne children, we would be justified often in whatever risk we might entail of unsatisfactory results or later development of fibroids. Two cases were reported; one in which a young unmarried woman was relieved of a profuse menorrhagia due to a fibroid infringing on the endometrium, and the other in which fibroid and fibro-

sis of the uterus were removed by extensive resection extending to the internal os and the reconstruction of the uterus by suturing the lateral portions together. In this case the patient subsequently married and became pregnant three times without pathology except that she aborted in the first two pregnancies. Her last pregnancy, however, resulted in a robust, living child.—N. Y. Med. Jour.

—R—

Purging.

H. T. Byford, Chicago (Journal A. M. A. Feb. 15, 1919) says that while many things complicating the preoperative and postoperative periods have been done away with in simplified measures in surgery, preoperative and postoperative purgation has survived, though some are condemning it at the present time, holding it to be unnecessary and harmful. He discusses it in cases of intra-abdominal surgery, where it is a matter of some importance. The main argument against it is that it seldom cleanses the bowel, but often increases rather than diminishes the abdominal distention. An examination of the method in which it is ordinarily carried out in practice will explain. When the average surgeon prescribes a laxative to clear out the bowels, he allows food to be given a short time before operating and permits or orders more to be taken before the laxative has quit working. The result is that instead of cleansing the bowels it only moves things along, expelling old fecal matter, while the stomach is delivering food into the duodenum for the bacteria to get to work on, and the consequence is the bowels become distended, whatever its previous condition. The question is whether a laxative can be given to accomplish what we give it for, and if so how. Byford thinks it can, if what he calls the four R's are observed, namely, the right laxative, in the right dose, at the right time, and under the right conditions. The material for the renewed formation of gas should be kept out. The last food that the patient takes before taking the laxative should have time to leave the duodenum

and be absorbed before the rapid peristalsis of purgation occurs. After the purgation has ceased none but easily digested food in properly regulated quantities should be given, such, for instance, as the quickly absorbable forms of sugar, meat extracts, etc., or if the patient is very weak, predigested food, until the upper intestine has recovered from its fatigue and has resumed its normal function. The timing of the laxative should be such that any residual gas may have time to be absorbed; thus, for a forenoon operation, the laxative will have to be given early on the day before, or in some cases the night before that. For an afternoon operation it will be ordinarily required the night before the operation and sometimes earlier. The kind of purgation should be adapted to the nature of the operation, its location, whether long or short, nature of anesthesia, etc. The patient may come half starved at first, and only need an enema. Everything should be suited to the case. The colon bacillus is not very virulent and persons with normal bowels may not need stirring up with laxatives before operations. As to postoperative purgation, the cases are divided into four classes, those in which the character of the operation requires early purgation, those in which it requires delay, those in which the indications are relative, and those in which the question of purgation is not dependent on the operation. Cases requiring early purgation are those in which a large incision of the middle or lower abdomen is made in connection with considerable displacement of intestinal coils, and sufficient traumatism to cause subsequent adhesions. Cases in which there has been resection or repair of an intestine usually require dieting and delay in purgation until a certain amount of exudate has been formed to cover and protect the intestinal suture lines. Cases in which sutured or denuded areas have been left are not so liable to the formation of extensive or permanent adhesions if peristalsis is kept fairly active from the time of operation. Early purgation may not be necessary but may be de-

sirable. Gas accumulation may require it in one case, while in another diet or washing out the stomach or postural treatment will suffice. Cases in which the incision has been small with little exposure or manipulation of the intestine, and in which all ligatures and denuded surfaces have been covered, will require purgation or abstention from it according to the conditions present. They may have spontaneous movements without drugs or may merely need enemas to assist nature, while others who are accustomed to laxatives may need them. Patients who have been dieted and in whom the anesthetic has disturbed the stomach, will do better without a bowel movement for two or three days. A routine method may be valuable to have on record but not to be followed out without modification according to circumstances.

—————R—————

Styptics.

Ordinary bleeding has a strong tendency to stop spontaneously with the formation of a clot, so that the benefit attributed to a drug that has been used as a hemostatic cannot easily be evaluated. Evidence of the current confusion of cause and effect in relation to local hemostatics has been furnished by P. J. Hanzlik. In general he finds that the local application of vasoconstrictor and astringent agents diminishes or arrests local hemorrhage, while vasodilator and irritating agents (without astringent action) increase local bleeding. The value of the newer thromboplastic agents of the kephalin or tissue extract type is considered as still uncertain. Epinephrin remains as the most efficient and desirable hemostatic agent. Tyramin and pituitary extracts were found efficient and, unlike epinephrin, they do not increase bleeding later. Astringents were found variably effective, ferric chlorid and tannin standing highest, while alum was disappointing. The vaunted cotarnin salts (stypticin and styptol), antipyrin and emetin were found to increase bleeding on local application. (Jour. A. M. A., Feb. 22, 1919, p. 577.)



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Trigeminal Neuralgia.

H. H. Martin, Savannah, Ga. (Journal A. M. A., Dec. 14, 1918), holds that the injection of the ganglion of Gasser through the foramen ovale for the relief of trigeminal neuralgia will be eventually accepted as the operation of election. It is, of course, a delicate operation, and if improperly directed, the needle may enter the foramen spinosum, the jugular foramen, or an anomalous foramen transmitting an emissary vein known as the foramen Civinini, occasionally found just below the foramen ovale. If passed too far through the foramen ovale, injury is possible to the cavernous sinus or even the internal carotid. But all such accidents, however, can be guarded against, and the procedure, though formidable, is not so much as to gasserectomy, and gives equal relief without causing such bad results as may follow the other methods. The indications are the same as those for gasserectomy, and there are no serious contraindications. It is Martin's opinion that favor of the direct injection of chemical surgical methods should be abandoned in benumbing agents, and of these alcohol is the best adapted. The technic of the operation is simple but the ability to locate and enter the foramen ovale is obtained only by extensive and patient trial on the cadaver. If the pain is limited to the area supplied by the third branch only, the injection may be limited to this branch, but if the first or second branches are involved the needle should be inserted into the body of the ganglion until the sensory root is reached. The only serious disadvantage involved is a neuroparalytic keratitis which he has seen in about 30 per cent of all successful injections. This, in most instances, recovers in due time without injury to the eye. Martin quotes at some length from Winfred Harris of London, as setting forth some essential facts, but embodying some conclusions with which he does not agree, such as Harris' view of the need of sewing up the eyelids to avoid the keratitis, and his advice as to a shallow

(Continued on page xvii)



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(3005)

(Continued from page xiv)

injection of the ganglion. The details of the technic are described. The author uses as a preliminary an injection of 0.5 per cent solution of cocain or a 2 per cent solution of procain. The immediate results of a deep injection, as advocated by Martin, are anesthesia of the entire area of the fifth nerve territory, persisting for a variable time, and an analgesia which in a great majority of cases is permanent. Seven cases are reported and the article is illustrated.

—R—

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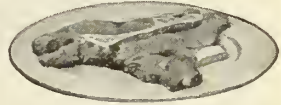
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Kansas Medical Society

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Hematuria.

Read at the Annual Meeting of the Kansas Medical Society held at Kansas City, Kansas, May 1, 2 and 3, 1918.

C. F. YOUNG, M.D., Ft. Scott, Kan.

The term Hematuria is generally understood to mean the presence of blood in the urine. This does not imply that it be macroscopic, for blood may be present and undetected without the use of the microscope or by chemical tests, and yet be of sufficient quantity to impair the patient's general health. Too little importance is generally attached to the presence of blood in the urine, both by the physician and the patient; and as a symptom it cannot be too strongly emphasized. Quite often the hematuria is painless, and possibly symptomless, so that a correct diagnosis from the presence of this symptom alone is impossible. Instead of an accurate diagnosis being made, various indefinite terms are used to describe the hematuria, and all sorts of drugs are administered with the assurance that the hemorrhage will be checked. By far a better procedure than to treat hematuria symptomatically, is to determine the origin and the cause, if possible, in every case.

Occasionally the question arises whether blood is present in the urine or not, especially if the amount present is small and the red blood cells have hemolyzed. In such cases it is well to remember that urine may be of a greenish color from reduced hemoglobin, and not suggest the presence of blood at all. In such cases the presence of Hb. will be readily detected by the use of the spectroscope or by chemical tests.

On gross examination the source of the

blood may only be made out by the physical condition in which it is found. Diffuse blood would suggest its being of high origin. Blood clots, that it was coming from the ureters; while large clots would make one think that it was of vesicle origin. Further than these mere suggestions, examination of the urine offers very little direct help and a cystoscopic examination should be made to demonstrate the real source of the hemorrhage.

It is quite important to make an early diagnosis in every case of hematuria, in view of the fact that a greater per cent of these is due to neoplasms and tuberculosis. In these conditions an early diagnosis is necessary to obtain the best results. Unfortunately the majority of patients give a history of several months to several years duration before presenting themselves for a thorough examination. In fact it seems to be as a last resort instead of early when their chances for recovery are so much better.

With the modern methods of diagnosis the origin and cause of the hematuria can be obtained in the vast majority of cases. It may not be possible to make a definite diagnosis at one examination, and frequently requires many examinations. But when we consider that the cases are nearly all due to some organic lesion it is well worth while to run the gamut in making an accurate diagnosis. Profuse painless hematuria may be and often is the initial symptom of nephritis, and these cases may have to be followed over long periods of time before a definite diagnosis of the nephritis can be made. In other cases in which at first no diagnosis, or only a ten-

tative one, is made, on further study will reveal the presence of tubercle bacilli. Because of the difficulty in demonstrating the latter bacilli, it is well in all doubtful cases to inoculate guinea pigs, and in so doing we are often able to make a diagnosis early in renal tuberculosis that would otherwise be missed.

From its site of origin, hematuria may be classified as coming from the kidneys, ureters, bladder, and urethra.

Hematuria of renal origin from whatever cause is always an important symptom. It occurs in the course of a great many diseases. The amount of blood may vary from a profuse hemorrhage to a few cells detected microscopically, and may persist for days, weeks, or even months. The hematuria may be intermittent, the attacks occurring at longer or shorter intervals, during which the urine is free of all traces of blood; or it may be continuous over a long period of time, during which the amount of blood lost is enormous.

It is customary to divide the cases into two main groups: (1) Those due to local causes; and (2) those due to general conditions. In the first group we have (a) inflammations, (b) thrombosis and embolisms, (c) traumatisms, (d) parasites, (e) calculi, (f) tuberculosis, (g) tumors, both malignant and benign. Under general conditions are included (a) infectious diseases, such as typhoid, scarlet fever, malaria, yellow fever, pneumonia, etc.; (b) diseases of the blood, leukemia, hemophilia, scurvy and purpura; (c) poisons and intoxications, such as cantharides, turpentine, quinine, etc.; (d) pregnancy and lactation.

In all of these cases the hemorrhage may be said to be symptomatic. There still remains a large group of cases of obscure etiology which has attracted quite a great deal of attention in the past few years, in which there is still a diversity of opinion. To this group belong those cases which are designated by the term "essential hematuria." The latter term is only a cloak to hide our ignorance as to

the real cause of the hematuria, and fewer cases are placed in this group from day to day. In many cases there is a diffuse glomerular nephritis. Fenwick first called attention to the presence of papillary nevi of the papillæ producing painless hematuria, reporting three cases. Other cases have been reported of a similar nature. In almost all of these cases the hematuria is unilateral. In treating this condition operation seems to be the procedure of choice. All sorts of operations from nephrotomy to nephrectomy have been done with the preference given to the former. Of twenty nephrotomies performed by Bunts, nineteen were cured and one death resulted. Of eleven nephrectomies, one was fatal. Dr. Hugh H. Young reports the cure of a case of unilateral hematuria by the injection of adrenalin through the ureteral catheter.

Profuse hematuria has been shown by a number of observers to be not infrequently caused by diffuse nephritis, without urinary findings. The fact that patients thus affected often have recurrences of symptoms without impairment of their general health is no evidence of the absence of structural changes in the kidney. Colic and hematuria may be the result of renal tension.

In the case of renal calculus, it must be a very unusual case in which a positive or negative diagnosis of stone in the kidney or ureter cannot be made. In very fleshy persons it is perfectly possible to miss the diagnosis. In every good X-ray plate the outline of the kidney should be shown as well as the shadow of the stone. The treatment of this condition is invariably operative.

Tuberculosis of the kidney is not an infrequent condition. Kroenlin states that 30 per cent of all surgical diseases of the kidney are tubercular. When it is considered that in the terminal stages of tuberculosis, little remains but a pus sac, obliterating all traces of the tubercular process, it may be safely asserted that over half the suppurative conditions found in the kidney, when a stone is not found, are

due to tuberculosis. Its unilateral nature in the beginning has been firmly established, and even when death occurred from renal tuberculosis one kidney was found sound in 67 out of 191 cases (Kapsammer). That the disease begins in the parenchyma has been shown by the fact that no cases have been seen by operation or autopsy in which the disease was limited to the pelvis, ureter, or bladder (Keen). In rare cases a slight trauma or prolonged irritation from a calculus may be the exciting cause of tuberculosis of the kidney.

In tumors of the kidney, hematuria is usually the first symptom noted in the adult. Albarran reports this as the first symptom in 138 out of 257 cases studied. Hematuria occurred during the course of the disease in 235 out of 357 cases. The hematuria is usually profuse, painless, and symptomless, and not influenced by rest or exercise. The passage of clots through the ureter may cause renal colic. The hematuria may occur several years before any other symptom. Hildebrand reports cases in which the intervals between the appearance of the blood and other symptoms of tumor were from eight to twelve years. The hematuria in these cases may be so profuse as to cause very severe anemia.

In children the hematuria is much rarer than in adults. Albarran reports it only 22 times in 140 cases.

While hematuria of ureteral origin is rare, it does, however, occur, and is usually due to new growths or stone.

Hematuria of vesicle origin: Hematuria being only a sign of some disease, the chief interest pertaining to its study relates to the diagnosis of its source and cause; the proper treatment depending on these two points.

Causes are either general or local. The general causes include the discrasias of purpura, hemophilia, scurvy, malaria, yellow fever, cholera; and the toxemias of chemicals, such as turpentine, cantharides, etc. These need no comment.

Under local causes we would include the

following: (1) Circulatory disturbances; (2) trauma; (3) infection; (4) new growths.

Vesicle hemorrhage from circulatory disturbances occur with varicosities of the mucous membrane, or passive congestion from other causes, as in hepatic cirrhosis; also the condition met with in obstructive prostatic hypertrophy of long standing in which all of the urine is drawn off by a catheter at one time, thereby removing the counter pressure, producing severe passive congestion of the whole of the urinary tract, causing a hemorrhage, often suppression of urine and death.

Trauma: Injuries, direct or indirect, may produce vesicle hemorrhage. Rough catheterization is not an infrequent cause. The mechanical effect of foreign bodies, including calculi. Any external violence transmitted to the bladder may cause hemorrhage, viz: kicks, or falls, producing contusions or ruptures.

Infection: Tuberculosis or other infections lead to inflammation or ulceration and are frequent causes of hematuria. This form is not likely to be severe and may only be microscopic in amount. The parasites of the *filaria sanguinis hominis* and others have been spoken of as causing hematuria, though this form is very rare.

New Growths: Tumors furnish the most severe degrees of vesicle hemorrhage. Papilloma and carcinoma being especially inclined this way. Vascularity being the main feature of these growths, and the friability of the structures leads to breaking down and hemorrhage. Under such circumstances with the cystoscope one may see a steady flow of blood coming from the bladder wall. Such hemorrhage is independent of exercise and may come on by night as well as by day. The diagnosis is made more easily in these cases by the cystoscope, and at the same time the nature of the cause can be made out and will give the most direct clue to the appropriate treatment. If seen early, practically all of the villous papillomata respond readily to fulguration, but unfortunately the malignant papillomata and

carcinoma does not respond well to this method alone.

Bladder stones show hematuria in the vast majority of cases. Although the bladder may be absolutely packed full with one large stone and the patient apparently not uncomfortable and notice nothing wrong with his urine. Diagnosis in these cases is made by the cystoscope and X-ray. Dr. Baetjer states that approximately 30 per cent of bladder stones do not cast a shadow to the X-ray. All will show with the cystoscope unless imbedded in a diverticula.

Hematuria of urethral origin may be due to the following conditions: Papillomata; prostatic hypertrophy in old men; simple ulcers; strictures; verumontanitis; bleeding from varicose veins; and bleeding from a mucous membrane that shows no pathological lesions. Dr. H. A. Fowler, of Washington, D. C., reports an interesting case of this kind which occurred on Dr. Young's service at the Brady Urological Institution a number of years ago in a young man of 21. It had persisted for several years and was treated by injections, indwelling catheter, external urethrotomy, and finally checked by use of a copper electrode introduced into the penis and attached to a galvanic battery.

Conclusions:

(1) The three most frequent causes of profuse hematuria are, tumor, stone, and tuberculosis.

(2) Hematuria being a frequent symptom of tumor formation in the urinary tract, this should be considered in every case of painless, profuse hemorrhage, until the possibility is excluded.

(3) The use of the term "essential hematuria" should be discouraged, and the real cause of the hemorrhage searched for.

(4) Each patient suffering with hematuria should be impressed with the seriousness of same and the necessity of determining the exact cause where possible.

—————R—————

It is not enough to work your mind, you must mind your work.—Theodore Roosevelt.

Training Schools for Nurses in Kansas.

SISTER CATHERINE VOTH, Newton, Kan.

Read before Kansas Hospital Association.

Every person here today is interested in the welfare of the public; interested in the art of medicine, ever struggling upward in the effort to become an exact science; interested in factors relating to the attending of the sick. The medical field with its various departments and their many branches has become so broad and complex that the physician is no longer able, unaided, to properly serve his patients. Doctors, and in civilized countries the laity, have long felt the need of reliable trained help in time of sickness. History tells us that with this growing need for competent help for the sick, there also grew up a "sister profession" to that of the medical profession—"Nursing," the profession of nursing, the value of devoted services and the demand for trained help once having been recognized by the medical profession and by the public, people at once began to plan how to supply the demand. Thus colleges of nursing sprung up in a night in various communities in our country. These colleges—or as I shall call them "the training schools of yesterday," were quite unlike the "training schools of tomorrow." They flooded the land with advertisements guaranteeing to give nurses a training and qualify them for, or, as they termed it, "turn them out" for the work in from three to six months. The management of these training schools and hospitals was in the hands of doctors, or occasionally a retired business man or a minister received the distinction of being elected manager of the establishment. There were no particular requirements of personal fitness or qualifications for the nurse making application for training. No stress was laid on educational attainments, nor on culture or refinement or many other essentials which are necessary to make a good nurse. In this training school of yesterday there was no outlined course of study, text books were unknown, theoretical training was

sadly lacking, and ethics were not taught at all. The nurses' duties were very simple, her education and training were complete when she had learned to make a bed, wash the patient and prepare the food. These conditions as they existed in the training school of yesterday resulted in turning out many nurses of an inferior rank who had no high ideals and only a very vague understanding of the work as a whole, consequently they could not by virtue of their knowledge, skill or tact command the respect of the public. The doctors undoubtedly appreciated the work of the nurse, but looked upon it as being a trade or merely skilled labor.

It is a law of Nature that every worthy cause keeps on developing—so it was with nursing. Many broad-minded people watched with interest the developments in the nursing field and hailed with joy the establishing of the first chartered training school for nurses in America in New York in the year 1873 when Sister Helen, a pupil of Florence Nightingale, came over from England. From the time of the opening of that school we notice a gradual change to better conditions in the nursing field—and we find that better nursing for the sick came with the same pace and rapidity as people, and doctors in particular, recognized the need for good training schools for nurses. The training schools of today have struggled for forty years, trying to conform to a standard, to obtain protection, to establish a code of ethics and regulated responsibilities and receive recognition—these being essentials of a training school in order to qualify nurses and educate them for a great profession which has for its sphere the care of the sick, their work supplementing that of the scientific physician and surgeon. Fraternities, organizations of public-spirited people and legislative bodies have contributed their share in laying substantial foundations for nursing which is no longer considered merely skilled labor or a trade, but which, due to more efficient services given by nurses from the best schools, in our country is recognized as a profession.

We know that the hospitals all over the state are making great efforts to render good services to the sick, but we realize also that we under our present system in our training schools fall short of what we would do and could do if we would organize, systematize and strictly abide by the laws, rules and regulations laid down by a committee which has given this matter its careful study. We believe that the problem of giving skilled nursing to every class of patients in our great state not only to those who can pay but to all those who need it, will eventually be solved by well organized training schools for nurses. In 1913 the nurses, with the help of doctors and attorneys, drew up the law, rules and regulations governing examination and registration of nurses. In this original law which was enacted by the legislature of the State of Kansas, we had a beginning, a foundation for order in the nursing field; but in the next legislature an amendment was made which handicaps progress in establishing a regulated system among hospitals and training schools. We feel that we must come to some understanding and agreement as to a standard, a well balanced curriculum of study and also as to who shall teach in such a training school. The training school of today is a part of the hospital, used by the hospital to take care of its patients; we cannot separate these two departments. Instructions and demonstrations, theory and practice go hand in hand. The training school needs the hospital and the hospital certainly needs the training school. We must needs admit that the training school is the fundamental basis upon which the hospital grows and develops.

May we invite the advice and the friendly criticism of this organization and improve upon the present system of training? The board of examiners is not trying to harm the smaller hospitals, on the contrary we would like to help them solve their problems. The law now requires that an applicant for state examination and registration has had two years of training in a school connected with an

incorporated hospital, and that a registered nurse be in charge of the training school. The curriculum of study is on a basis of 106 lessons, or three lessons a week during a term of nine months each year, in schools giving a two-year course. We believe it takes at least two years of diligent study and close application for a woman to become a competent nurse, and we believe also that we are not asking the schools to teach any branches which are unnecessary, and yet we hear from different parties that they find the curriculum of study too rigid—it should not be so compact so the pupil nurses get more time for recreation and also so they need not be absent from practical work so much of the time.

The fact that the training school of today is far from being ideal shall not discourage us in our effort to become more and more efficient. We must ever strive to improve so the school of tomorrow may become the means to greater accomplishments in efficiency. Let every training school of tomorrow be connected with a modernly equipped hospital having a capacity of ten, twenty or fifty beds, whatever the standard shall be. Let all schools have the same requirements for applicants so that the classes of nurses eventually may consist of women with good health, a lot of common sense and sufficient education coupled with strong intellectual and moral faculties. Let every hospital maintain a class room equipped with the necessary text books, books for reference, charts, etc., and last but not least be supplied with good instructors. The time is coming when the instructors in our training schools for nurses will be required to have had special training for their position. Our own State of Kansas may before many years go by, maintain one training school in connection with one of our largest hospitals for the purpose of offering a special course of instructions to registered nurses who desire to specialize—be it in surgery, obstetrics, medical nursing, visiting nursing, etc. This special school may be authorized to grant degrees or

diplomas to graduate nurses who desire to take a position as instructor in some hospital training school for nurses. And such hospitals employing in their school salaried instructors, especially educated for that position, shall be recognized as registered schools in the state and graduates from such school only shall be eligible applicants to the post-graduate school or school of philanthropy and civics, whatever it may be called, to specialize. The results produced by such conditions in our schools would manifest themselves in greater success in preventing illness and more efficient nursing care to every class of patients in our state. This work of regulating and systematizing nursing cannot, however, be done by a few people; it is a vast humanitarian work that needs be done and that must be done in the interest of the common weal, therefore we urge the hearty co-operation of the medical profession and ask that every doctor demand that every woman who assumes responsibilities in the sick room for hire or wages shall show that she has had training and has obtained her license for the task.

—————R—————

A student in public hygiene explained the modus operandi of the rest treatment of tuberculosis: When a person with tuberculosis is kept at rest, the anti bodies form sacs around the tubercle bacilli, thus rendering them harmless, but when the person moves, their sacs are likely to be broken and the tubercle bacilli are liberated and become harmful again.

—————R—————

The American Public Health Association will hold its next annual meeting in New Orleans October 6-9, 1919. The executive committee has already begun preparations to make this a banner meeting. With this end in view we take the liberty of asking your co-operation to make it a great success.

—————R—————

I am convinced that to maintain one's self on this earth is not a hardship but a pastime.—Thoreau.

THE JOURNAL

of The

Kansas Medical Society

W. E. McVEY, M.D. - - Editor

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The Annual Meeting.

A part of the program for the meeting at Ottawa appears in this number. You will observe that this is a very excellent program as it is; and whether or not any additions be made to it, the two days will be fully occupied. Look it over carefully and prepare yourselves not only to hear some good papers, but also to take part in the discussions.

Every member of the society who can possibly do so should attend this meeting. There are still a good many active members in the army, and in some parts of the state the epidemic of influenza is keeping every doctor in the community busy. For these reasons one should feel it a duty to spend a day or two days at this meeting. It will be a very profitable and interesting vacation.

* * *

There are entirely too many members of the society who feel that they have done all that is required of them when they have paid their annual dues. One must decide for himself whether in becoming a member of such an organization he assumes any obligations or responsibilities, but there are benefits to be derived from such organizations, that accrue only to

those who attend the meetings and take an active part in its affairs. There are great possibilities in an association of fifteen hundred physicians and if once they could be made to realize this fact and would work together for the good of all, the medical profession of Kansas might set the pace for this country at least.

In most every field of work but ours the importance of combination has been demonstrated. The only feature of our organization which approaches the practical features of these other combinations is our defense plan. The benefits afforded by this have been so clearly demonstrated that one is surprised at the indifference shown to any suggestion for the addition of other features of practical value.

* * *

It might be well worth while to have, at Ottawa, a meeting for secretaries of county societies. This could easily be arranged for some time during the two days when it would not interfere with other business. If the secretaries would talk over their plans together, many very valuable suggestions would certainly be made. We are fortunate in having some "live wires" in our county societies; men who succeed in getting members and who succeed in getting them to attend the meetings. They will no doubt have valuable suggestions to offer. It is really the secretary who makes the society.

—————R—————

Sanitation of Vice?

Considering the mortality and the extent of the disability in the women of this country caused by venereal diseases, it seems rather strange that the most active opposition to the regulations proposed for the control of these diseases should come from a woman, and especially from one who is a graduate in medicine and who has had unusual opportunities for investigating social conditions in many parts of the world.

Dr. Katherine Bushnell is making a vigorous fight against what she characterizes as "state regulated fornication." In a pamphlet entitled "Plain Words to

Plain People," she says: "The woman sinner is to be chased from pillar to post, and when at last caught, very severely punished. This makes a grand show of virtue to the unthinking public—but, at the same time, the woman's partner in vice is to be protected *in his fornication, and at your expense!*"

Legislation which, in itself, is equitable, just and beneficial, may become unjust and obnoxious in its administration. Too zealous an enforcement of a wise regulation may result in the persecution of both the innocent and the guilty. Is this true of the regulations which have recently been promulgated for the control of venereal diseases?

We do not believe that any one is justified in concluding that such is the case from the administration of the regulations made by the government for the protection of its soldiers. In such emergencies our ideas of justice may be outraged with impunity. In this emergency individual rights and individual liberty were submerged in the great conflict for a world's rights and a world's liberty. If men were apparently favored it was because they were needed for such service as they were able to perform in the army.

Now that the war has come to an end and the army is being demobilized, there is no reason to assume that the same rules regarding those afflicted with venereal diseases will not apply to both men and women.

In stating the methods used in the social hygiene movement, Dr. Bushnell says: "Young women, whether they have been married or otherwise, charged (not proven guilty, this may be done even before trial) with vagrancy, suspected solicitation or suspected prostitution, or with open prostitution, are to have the most private part of their person subjected to ocular and instrumental inspection, and to have those parts manipulated by the doctor's hand until a discharge is secured for microscopical examination."

No doubt such a bare statement as this will shock the sensibilities of the plain

people to whom it is addressed. It certainly is not contemplated by the promulgators of these regulations that virtuous women or those who conduct themselves in an orderly manner will ever be charged with the offenses which may subject them to such an examination as the one described. On the other hand those who are likely to come within the jurisdiction of these regulations are not likely to suffer any great shock to their modesty by this examination. They do not so much dread the exposure of the "most private part of their person" for the inspection by a physician as they dread the exposure of their diseased condition to the clientele upon whom they depend for support.

It is possible, of course, that an innocent woman may some time be subjected to embarrassing questions and it is possible that, through jealousy and misrepresentation, a pure and innocent woman may be charged with an offense and subjected to examination, but it is not likely to occur. There are few criminal laws under which some innocent person has not suffered, and yet our criminal laws are undoubtedly of the highest importance to our social security.

We do not believe that any large or influential part of the people will look upon these efforts to control the spread of venereal diseases as does Dr. Bushnell. The people who fully realize how dangerous these venereal diseases are, how far reaching in their effect, how destructive to health and happiness, will hardly object to these regulations for their control because an innocent person may occasionally be made to suffer embarrassment.

Education and moral teaching has done little, if anything, toward the eradication of venereal diseases; nor are they likely to do so until some one has produced a vaccine for gonorrhea and another for syphilis.

Because of the association of these diseases with vice, there are extreme moralists who would oppose all interference by the state in their control; who would have the state perpetuate an economic sacrifice

in order that a moral code may not be violated. It may be possible for one of this class to harmonize his ideas of christianity with the moralistic dogma that a "man must suffer the penalty of his crime," but you will view with less complaisance the thousands of disabled, maimed and suffering women, who have committed no sin and are guilty of no crime to be punished for.

Dr. Bushnell and her adherents are pleased to call this a movement for the "Sanitation of Vice," but by whatever name it may be called we are still of the opinion that it bids fair to do more for the cause of humanity than any sanitary measure yet inaugurated. In its final evolution we hope to find the quarantine regulations for the control of venereal disease as stringent and efficient as ever they have been in the control of cholera, yellow fever or small-pox.

The interdependent basic essentials for the highest plane of civilization are health and happiness, efficiency and prosperity, wisdom and morality; and health is the fundamental essential to all.

—————R—————

Municipal Free Medical Service.

The citizens of Topeka have just recently elected a new mayor. In his campaign for this office, Mr. Corwine published a number of proposals for the city's welfare which he is pledged to carry out, or try to carry out. Among other things he proposed to do was to establish free medical service for all citizens who desire it. We shall await with much interest the further evolution of his plan. It is a large undertaking—not impossible of accomplishment, and one which will draw heavily upon the tax-paying public.

—————R—————

A Medical Member of the Board of Administration.

It is rumored that Dr. Uhls, formerly superintendent of the Osawatimie Hospital, is to be a member of the Board of Administration. We do not imagine this is in any way intended as a compliment to the medical profession but rather is an

evidence that Governor Allen has recognized the important service which a physician may render the state in such a position as this. With all of the state hospitals under the management of this board it seems strange that our former governor did not recognize the need of a medical man for one of these positions.

—————R—————

Dr. C. C. Coddard, Councillor of the Second District, who occasionally "drops into poetry," has become reminiscent of late. The constant sight of men in uniform, or possibly a scent of battle across the seas, has awakened memories of those early days when he served as medical officer with troops in the wild and woolly west, at any rate the last number of *The Medical Pickwick* publishes one of his stories of those times which is quite interesting. It is an amusing little story which portrays in characteristic Goddard style the supreme egotism of some army officers and the ridiculous situations sometimes occasioned by adherence to that fetish of the army, discipline.

—————R—————

Dr. Alexander Haggart, of Elgin, Kansas, formerly of Ottawa, has recently been operated upon at a hospital in Kansas City for a lipoma in the submaxillary space and adherent to the carotid artery.

—————R—————

Dr. L. V. Sams, formerly of Topeka, has located in Denver, Colorado. Dr. Sams was a commissioned officer in the M.R.C. and was stationed for some time at Fort Riley.

—————R—————

PROGRAM

Fifty-third Annual Meeting of Kansas Medical Society.

Committee on Arrangements—Dr. F. C. Herr, Dr. H. W. Gilley, Dr. R. C. Dugan, Dr. H. L. Kennedy.

Reception Committee—Dr. E. B. Gossett, Dr. V. E. Lawrence, Dr. C. W. Hardy, Dr. J. B. Davis, Dr. W. L. Jacobus.

Meeting to be held in the court house,

Ottawa, Kansas, Wednesday and Thursday, May 7-8.

ENTERTAINMENT.

Banquet at the Nelson Hotel, 5 P.M., Wednesday, May 7.

MEETING OF THE COUNCIL.

The Council will meet in the G. A. R. room at the court house, May 7, at 9:00 A.M.

MEETING OF THE HOUSE OF DELEGATES.

The House of Delegates will meet in the G. A. R. room at 4:00 P.M. Wednesday, May 7.

The House of Delegates will meet at 8:30 A.M. Thursday, May 8.

WEDNESDAY MORNING, 9:00 O'CLOCK.

President's Address—Dr. W. S. Lindsay, Topeka, Kansas.

"Treatment of Infected Wounds"—Dr. J. S. Sutcliff, Iola.

"Perforated Lung Following Broncho-Pneumonia"—Dr. F. A. Trump, Ottawa.

"Prostatectomy—Pre and Post Operative Management of Cases"—Dr. L. O. Nordstrom, Salina.

Subject given later—Dr. L. A. Cutter, Wichita.

"A Study of 750 Obstetric Cases in Private Practice"—Dr. E. A. Reeves, Kansas City.

"A Plea for the Earlier Recognition and Elimination of Chronic Infection of the Head"—Dr. E. N. Robertson, Concordia.

"My Experience at the Front"—Dr. J. G. Missildine, Parsons.

"Strictures of the Eustachian Tube"—Dr. E. C. Button, Great Bend.

"Clinical Data versus Laboratory Findings; the Correlation of Contradictory Data in Internal Medicine"—Dr. C. F. Menninger, Topeka.

WEDNESDAY AFTERNOON, 2:00 O'CLOCK.

"The Acute Abdomen"—Dr. W. E. Mowery, Salina.

"Fractures of the Femur"—Dr. R. C. Lowman, Kansas City.

Subject later—Dr. M. L. Perry, Topeka.

"Eye Examinations as Practiced in the Army"—Dr. G. A. Landes, Parsons.

"Dysmenorrhea"—Dr. L. K. Fast, Atchison.

"Personal Experiences with Gas in the St. Mihiel and Argonne-Meuse Drives"—Dr. R. H. Meade, Kansas City, Mo.

Subject later—Dr. W. P. Callahan, Wichita.

"Some Considerations in the Treatment of Purulent Appendicitis"—Dr. T. A. Jones, Hutchinson.

WEDNESDAY EVENING, 8:00 O'CLOCK.

"Hospital Standardization"—Mr. John G. Bowman, Chicago.

"The Treatment of Flat Foot"—Dr. Edward H. Ochsner, Chicago.

"The Handling of Patients at the Front"—Dr. J. F. Binnie, Kansas City, Mo.

THURSDAY MORNING, 9:00 O'CLOCK.

Program—School of Medicine, University of Kansas, Rosedale.

THURSDAY AFTERNOON, 2:00 O'CLOCK.

"Urethral Strictures"—Dr. E. M. Miers, Salina, Kansas.

Subject later—Dr. S. G. Smith, Oska-loosa.

"Experiences in Spinal Cord Surgery"—Dr. Allen B. Kanavel, Chicago.

"Neurosyphilis; Neurological and Psychiatric; with Notes on Treatment"—Dr. Karl A. Menninger, Topeka.

"Nasal Accessory Sinusitis"—Dr. L. B. Spake, Kansas City.

Subject later—Dr. H. Michiner, Wichita.

Subject later—Dr. Lydia A. DeVilbiss, Topeka.

—————R—————

Excerpts—By The Prodigal.

Belladonna is an excellent remedy for enuresis; especially in children from habit or caused by irritability of the mucous membrane at the neck of the bladder. Children require large doses.

A case cured inadvertently: Miss B., aged thirteen years, had a deep, irritable, painful ulcer of the right eye. It took several drops of a four grain to the ounce solution of atropin in as many hours to dilate the pupil. Each treatment the head was held to the right side so that the excess fluid flowed out and over the outer canthus, thus preventing the entrance of the fluid at the inner canthus, and passing down into the nose and poisoning the pa-

tient. The patient having to return and stay at home (some twenty miles distant) the mother of the girl was given a four-grain solution of atropin and a boric acid wash, saturated solution, and was instructed to bathe the eyelids of the affected eye and the right side of the forehead and face with water as warm as could be comfortably endured (the water having been boiled for thirty minutes). the eyelids and face dried gently and then to separate the lids and douche the eyeball with five or six dropperfuls of the warm boric acid solution, have the patient wink a few times and then put one or two drops of the atropin solution on the eyeball next to the nose with the head reclining to the right side, this treatment to be repeated every six to eight hours. Plain ground smoked glasses were worn in addition to the visor. The patient was brought to the office each week, and at the end of six weeks the ulcer had healed, and the eye was well. Before leaving the office the mother of the patient asked if the medicine used in the eye would stop the child wetting the bed; said that "She had wet the bed all her life until a week after they put the medicine in the eye, and that she had not wet the bed since." Like all good doctors who have helpful coincidents happen now and then, she was assured that the eye medicine wrought the cure. The relief proved to be permanent.

In speaking of atropin, it is the sulphate of atropin that is used. It requires 300 parts of water, at a temperature of 60 degrees Fahrenheit, to dissolve atropin; whereas sulphate of atropin is very soluble in water.

In Ye Olden Time, medical journals published little therapeutic helps, reminders, or memory refreshers for the general practitioner more frequently than they do now; items like the following:

Aphonia, due to fatigue, is relieved by sulphate of atropin one one-hundredth to one-seventy-fifth of a grain.

In bronchitis or in nasal catarrh (cold) when the secretions are excessive, two or three drops of the fluid extract of bella-

donna given every three or four hours will give relief.

The ptialism of pregnancy is benefited by two or three drops of the fluid extract of belladonna three or four times a day.

In scarlet fever or measles where the rash does not come out well, full doses of the fluid extract of belladonna will give relief, generally.

Belladonna and its alkaloids like opium and its alkaloids may render the bladder dull or insensitive to stimulation by the urine and cause its retention. This fact must be kept in mind.

In congestive forms of headache, where there is pallor of the face, a full dose of belladonna will often give relief. Headache from anemia is made worse by belladonna.

In case of poisoning by opium or its alkaloids, atropin is the antidote. It is safe to inject hypodermatically from one-one-hundredth to one-seventy-fifth of a grain of atropin in the beginning.

Constipation, like the poor, is always with us—always will be. It is said to be a condition and not a disease. But it is a forerunner and it foreglints trouble. Nature has put one over on the lower animals in favor of man in some things. But not in elimination by the alimentary route. It is exceptional to find a brute animal constipated always, and it is an exception to find one of the genus homo that is not constipated, especially the female variety.

The brute has it on man in its esthetic(?) conduct and clothing, but it would seem that man is ahead in common sense; but he is not in this respect. Nature gives man warning the same as the brute, but he neglects or heeds not the warning. The local specific warning ceases and a general call is put in and the penalty for Nature's broken law must be paid. A whole train of trouble and suffering is the result. Teaching does not teach. Knowing does not result in doing. Repetition follows repetition and man keeps going around in a circle. All remedies tried so far have failed to cure the habit of ennui

or negligence of the obstipator.

An appeal to the pride of being clean inside as well as outside is not a sufficient stimulus to action on the part of the derelict. Use the other psychologic agent—shame. Shame to be known as a living, walking enteric septic tank full of fertilizer. A clean skin is an important factor in the health of the body, and the possessor of it is not loath that it be known. But if in addition they are taught that it is vital to health and equally creditable that the inside should be kept in a normal aseptic condition and how to do it by obeying Nature's demands promptly—exeunt constipation, almost.

The enema is a useful mechanical therapeutic agent. Like all good things it is overworked. It may be harmful as well as useful. It will cause constipation as well as it will relieve it. When used too often or when too large a quantity of fluid is used it may render the rectum insensitive or balloon it and the last condition of the patient is worse than the first.

High enemas used often are liable to bring on colitis, and proctatinitis, and should not be given by the patient, but by the physician. It is the duty of every physician to warn the patient of the danger of the indiscriminate and habitual use of the enema.

The legislature of Ohio, by a vote of eighty-two to twenty-three, has refused to enact a law to permit Christian Science practitioners to charge fees for the treatment of the sick.

The average man and legislator cannot understand the altruism and unselfishness of a man or set of men who will plan to interfere with their own business, and when a doctor tells such an one that the proposed regulations or law is to save life and lessen sickness, he classes him as an Eli Perkins or Munchausen and forgets him, or fights such fool talk. The medical profession of Ohio pursued the right course. "They spoke easy and carried a big stick."

The big stick was his self interest and a personal responsibility of the legislator to his home folks.

Those little, irritable, burning, painful, chronic ulcers of the mouth and mucous surfaces are cured by Fowler's Solution of Arsenic. The dose in the beginning should be the minimum (two drops), increasing the dose one drop each day to tolerance, and continued for a month or until the ulcers disappear, with three or four days of rest at monthly intervals.

To avoid or to overcome the unpleasant physiological effect of iodide of potassium, give with it three drops of Fowler's Solution of Arsenic three times a day, gradually increasing the dose as indicated.—Kansas Medical Journal, 1894.

It is claimed that Virchow not long before his death said that if he had his life to live over again he would devote himself to proving that the germ sought its natural habitat in disease, rather than that it caused the disease.(?)

The United Presbyterian says "President Wilson carries a buckeye in his pocket as a charm. His explanation is that he carries it on the advice of his physician." Grayson?

Doctor, whatever headway you make must be made against opposition. Don't wait for help nor for dead men's shoes.

It is said that castor oil applied to a wart two or three times a day for a few months will destroy it.

Is it possibly true as claimed that 75 per cent of drug fiends are made by doctors?

Being human is a good religion.

Heavy meat eaters are ill tempered.

DEATHS.

Dr. Joseph E. Sawtell, who since 1898 has been a practicing physician in Kansas City, died April 4 of pneumonia at his home, 632 Orville Avenue, Kansas City, Kansas.

Doctor Sawtell was one of the founders of the College of Physicians and Surgeons, an early day medical school, and was connected with the staff of St. Margaret's, Bethany, Bell Memorial, Christian and St. Joseph hospitals. In recent years he had devoted his time almost exclusively to diseases of the throat and ear. He was a Fellow of the American College of Surgeons, a former president of the Kansas Medical Society, and several times president of the Wyandotte County Medical Society. Doctor Sawtell was born in McMinn County, Tennessee, May 20, 1859. He was graduated from the College of Physicians and Surgeons of Baltimore in 1886. He came to Kansas, starting in general practice near Salina in 1885.

It was mainly through Doctor Sawtell's efforts that the Medical School of the University of Kansas was moved to Rosedale.

Doctor Sawtell is survived by his wife, Mrs. Gertrude A. Sawtell; two sons, Lorraine A. and Joseph N. Sawtell, of the home address; one daughter, Mrs. C. R. Greenlees, of Lawrence, Kansas.

Dr. Deborah K. Longshore, aged 77 years, died in Topeka, March 24. She graduated from the Women's Medical College of Philadelphia in 1872 and located in Topeka in 1879.

Up to the time of her retirement from active practice, about ten years ago, Dr. Longshore was a member of the Kansas Medical Society and always an active participant in its meetings.

She was well known throughout the state, and had a host of friends both in and out of the profession.

William Ernest Barker, Chanute, Kan.; American Medical College, St. Louis, 1878; aged about 73; for a time treasurer of

the Kansas Medical Society; died at his home, March 13, from cerebral hemorrhage.

James Parker Blunt, Ottawa, Kan.; Ensworth Medical College, St. Joseph, Mo., 1900; aged 44; a member of the Kansas Medical Society; died at his home, March 18, from pneumonia following influenza.

William B. Callender, Stockton, Kan.; Drake University, Des Moines, Iowa, 1887; aged 63; at one time a member of the Kansas Medical Society; for twenty-six years local surgeon for the Missouri Pacific system; died in the Concordia (Kan.) Hospital February 5.

Levi Horner, Wichita, Kan.; Kansas City, Mo., Medical College, 1886; aged 62; member of Kansas Medical Society; for several years physician of Sedgwick County and a member of the local board of education; died in a drug store in Wichita, February 6, from heart disease.

* * *

Raymond B. Houston, Seneca, Kan.; Central Medical College, St. Joseph, Mo., 1905; aged 36; former member of the Kansas Medical Society; died at his home, February 10, from pneumonia.

R

BOOKS.

Clinical Microscopy and Chemistry.

By F. A. McJunkin, M.D., Professor of Pathology in the Marquette University School of Medicine; formerly an assistant in the Pathological Laboratory of the Boston City Hospital. Octavo volume of 470 pages with 131 illustrations. Philadelphia and London: W. B. Saunders Company, 1919. Cloth, \$3.50.

The author presents in this book, in a very comprehensive form, the most practical and accurate methods for the chemical and microscopic examination of the blood, sputum, serous fluids, exudates, urine, gastric contents and feces. A chapter on histologic and autopsy technic is also added.

Short clinical descriptions are given in connection with the laboratory methods and particular emphasis is placed on the relationship between the materials com-

monly examined by the clinician, and the body tissues.

In all the procedures described the technic is carefully detailed and those points in which error is likely to occur are particularly mentioned.

Surgical Treatment—Volume III.

A practical treatise on the therapy of surgical diseases for the use of practitioners and students of surgery. By James Peter Warbasse, M.D., formerly attending surgeon to the Methodist Episcopal Hospital, Brooklyn, New York. In three large octavo volumes, and separate desk index volume. Volume III contains 861 pages with 864 illustrations. Philadelphia and London: W. B. Saunders Company, 1919. Per set (three volumes and the index volume): Cloth, \$30.

The third volume of Warbasse, which is now out, completes the set. In this volume the author has very carefully presented the subject of the treatment of hernia, the rectum and anus, the vermiform appendix, the liver and gall bladder, the genito-urinary organs, the testicles and scrotum, the female generative organs, the upper extremities, the lower extremities, amputations, plastic and cosmetic surgery, electricity and radium in surgical treatment, injuries from electric currents, radiation and gas poisoning, first aid to the injured, bandaging, the economics of surgical treatment. A separate desk index volume accompanies the complete set.

One of the very interesting chapters in the third volume is that on the economics of surgical treatment under which the author discusses the economics of surgery under competition, needed state control under group experts and under co-operation. He says: "The ultimate need of surgery, in order that it may attain its best form of expression, is that it shall be free. The surgeon, to do the best possible thing for the surgical patient, must be liberated from economic trammels. The practice of a great art can not be reduced to terms of barter. Freedom and co-operation are essential." The work as a whole is a masterpiece and deserves a hearty reception by the profession.

Essentials of Surgery.

A textbook of surgery for student and graduate nurses and for those interested in the care of the sick. By Archibald Leete McDonald, M.D., Johns Hopkins University, formerly in charge of the De-

partment of Anatomy, University of North Dakota; lecturer on Surgery, Nurses' Training School, St. Luke's Hospital, Duluth, Minn. Forty-six illustrations, cloth. Price, \$2.00. J. B. Lippincott Company, Philadelphia and London.

For the instructor in surgery in a nurses' training school it is sometimes difficult to determine how much of the subject he should teach and how best to teach it. The author of this little book has attempted to solve the problem and he has, at any rate, prepared a very satisfactory textbook for the purpose. It will be found very useful in the training schools, and will simplify the work of the instructor in surgery.

SOCIETY NOTES.

BOURBON COUNTY MEDICAL SOCIETY.

The Bourbon County Medical Society met in regular session, Fort Scott, Kansas, Monday evening, March 17, with seven members present.

The petitions of Dr. J. B. Rees, Mapleton, Kansas, and Dr. D. W. Sheeler, Devon, Kansas, were voted upon and elected to membership in the Society. This makes every white practicing physician of the regular schools of medicine of the county members in the Society, a thing that I have been working for for the past two and one-half years and have told you that I would do before I quit as secretary.

At the last meeting Dr. E. B. Payne gave a very interesting talk on Eclampsia, citing several cases that he had met in his practice. The subject was freely discussed by every member present, and was a very timely subject for discussion.

Dr. C. F. Young read a short paper on the theories of development of malignant tumors, with the present status of treatment of same. This paper was not very well discussed, as the subject is a ticklish one to the average practitioner.

After a general discussion of current medical topics the meeting was adjourned.

C. F. YOUNG, Secretary.

CRAWFORD COUNTY SOCIETY.

The Crawford County Medical Society

held its annual banquet January 7, 1919. After the banquet the following officers were elected for the ensuing year: President, Dr. D. O. Munson; vice president, Dr. A. L. Cowden; secretary-treasurer, Dr. C. M. Gibson; delegate, Dr. A. J. Dodds. Dr. H. L. Stelle was re-elected censor.

—————R—————

Proposals to Amend the Constitution.

(Second publication.)

Notice is hereby given, in accordance with Article XIV of the Constitution, of certain proposals to amend the Constitution and By-Laws of the Kansas Medical Society.

It is proposed to amend Article IV to read as follows:

ARTICLE IV—COMPOSITION OF THE SOCIETY.

Section 1. The Society shall consist of officers, councilors, delegates, members and guests.

Sec. 2. The officers of this Society shall be a president, three vice presidents, a secretary and a treasurer, to be elected by the House of Delegates for such terms of office as hereinafter provided.

Sec. 3. The councilors shall be twelve in number, to be elected by the House of Delegates, one from each Councilor District, and to serve for such terms as hereinafter provided.

Sec. 4. Delegates shall be those members who are elected in accordance with this Constitution and By-Laws to represent their respective component societies in the House of Delegates of this Society.

Sec. 5. The members of this Society shall be the members of the component county medical societies or other societies approved by the Council.

Sec. 6. Any distinguished physician not a resident of this state, who is a member of his own State Society, may become a guest during any annual session on invitation of the officers of this Society, and shall be accorded the privilege of participating in all of the scientific work for that session.

It is proposed to add the following, which shall be Article V:

ARTICLE V—COUNCILOR DISTRICTS

There shall be twelve Councilor Districts, comprised as follows:

First District: Nemaha, Brown, Doniphan, Jackson, Atchison, Jefferson, Marshall, Pottawatomie and Riley counties.

Second District: Leavenworth, Wyandotte, Johnson, Douglas, Franklin, Miami, Coffey, Anderson and Linn counties.

Third District: Woodson, Allen, Bourbon, Wilson, Neosho, Crawford, Montgomery, Labette, Cherokee, Elk and Chautauqua counties.

Fourth District: Shawnee, Wabaunsee, Geary, Osage, Morris, Lyon and Chase counties.

Fifth District: Rice, McPherson, Marion, Harvey, Reno, Stafford, Pratt and Kiowa counties.

Sixth District: Kingman, Cowley, Sumner, Harper, Barber, Sedgwick, Butler, Greenwood, Clark and Comanche counties.

Seventh District: Rooks, Osborne, Jewell, Mitchell, Republic, Cloud, Washington and Clay counties.

Eighth District: Lincoln, Ellsworth, Ottawa, Saline and Dickinson counties.

Ninth District: Cheyenne, Rawlins, Decatur, Norton, Phillips, Smith, Sherman and Thomas counties.

Tenth District: Sheridan, Graham, Trego, Gove, Logan, Wallace, Ellis and Russell counties.

Eleventh District: Barton, Rush, Pawnee, Edwards, Hodgeman, Ness, Lane, Scott, Wichita and Greeley counties.

Twelfth District: Mead, Seward, Haskell, Stevens, Grant, Stanton, Morton, Ford, Gray, Finney, Kearney and Hamilton counties.

It is proposed to change the present Article V to Article VII.

It is proposed to amend Article VI to read as follows:

ARTICLE VI—COUNCIL.

The Council shall consist of the president, secretary and treasurer, ex-officio, and twelve councilors, one councilor to be elected by the House of Delegates from each Councilor District. Besides its duties as mentioned in the By-Laws the

Council shall constitute the Finance Committee of the House of Delegates. Five Councilors shall constitute a quorum.

It is proposed to change the present Article VII to Article VIII, and proposed to change the present Article VIII to Article IX.

It is proposed to change the present Article IX to Article X, and amend it to read as follows:

ARTICLE X—TERMS OF OFFICE.

Section 1. The term of office of the president, vice-presidents and treasurer shall be for one year. The term of office of the secretary and of the councilors shall be for three years. All of these officers shall serve until their successors are elected and installed.

Sec. 2. The officers of this Society shall be elected by the House of Delegates on the morning of the last day of the annual session, and no person shall be elected to any office who is not in attendance upon that annual session, and who has not been a member of the Society for the past two years.

It is proposed to change Section 4 of present Article IX to Article XI—Defense Board.

It is proposed to change present Articles X, XI, XII, XIII and XIV to Articles XII, XIII, XIV, XV and XVI respectively.

It is proposed to change Sec. 9, Chapter IV of the By-Laws by striking out the following: "Divide the state into Councilor Districts, specifying what counties each district shall include, and,"

It is proposed to change Section 3, Chapter VI, by striking out the word "state" in the last line.

—R—

Regulations Governing the Scientific Research Fund.

The United States Interdepartmental Social Hygiene Board prescribes the following rules and regulations in conformity with that part of Section 6, Chapter XV, Public 193, 65th Congress, which provides that the sum of \$100,000 "shall be paid to such universities, colleges, or other suit-

able institutions as in the judgment of the Interdepartmental Social Hygiene Board are qualified for scientific research for the purpose of discovering, in accordance with the rules and regulations prescribed by the Interdepartmental Social Hygiene Board, more effective medical measures in the treatment and prevention of venereal diseases."

1. Appropriations from this fund will be made only to universities, colleges, or other suitable institutions that give satisfactory evidence of possessing a staff of scientific experts and an equipment of scientific apparatus, supplies and resources that will guarantee that the researches undertaken will be carried out under approved scientific conditions and in conformity with scientific methods.

2. Appropriations for this fund for scientific research will be made only for definite investigations that are described by the proposers in sufficient detail to satisfy the Interdepartmental Social Hygiene Board that there is a justifiable expectation that these researches "will discover more effective medical measures in the prevention and treatment of venereal diseases."

3. The universities, colleges, or other institutions proposing researches and asking for appropriations will furnish information on the following subjects:

(a) Name of institution requesting appropriation.

(b) Name, office, and address of official representative of this institution.

(c) Title concisely descriptive of research proposed.

(d) Laboratory in which research is to be carried out.

(e) List of more important scientific publications from this laboratory.

(f) Name and concise statement of the scientific training of the laboratory chief or director, or other individual responsible for the scientific policy of the laboratory.

(g) Laboratory staff, giving names, degrees, etc.

(h) Laboratory equipment and facilities, with a concise statement indicating

scientific and working capacity of the laboratory, and co-operating laboratories, departments, and agencies.

(i) Description of research proposed; outline plan in sufficient detail to show clearly its scientific character and justify the expectation that it will discover "more effective medical measures in the prevention and treatment of venereal diseases." Include references to important scientific literature bearing on research proposed.

(j) Probable cost. Give general items covering the necessary equipment and supplies, with an estimate of the probable cost of preparing and printing a report. Should not include the salaries of scientific investigators, but may include salaries for technical assistants.

(k) Will this institution be able to carry on the research proposed if it receives no financial aid from the Interdepartmental Social Hygiene Board?

4. Universities, colleges, and other institutions asking for appropriations will furnish the board with a budget made out on forms supplied by the board and will make an accounting of their disbursements in conformity with the rules of the Comptroller of the Treasury of the United States Government.

The United States Interdepartmental Social Hygiene Board, through its executive secretary, Dr. T. A. Storey, 1800 Virginia Avenue, N. W., Washington, D. C., announces the following appropriations from the Scientific Research Fund of the Board:

LELAND STANFORD JUNIOR UNIVERSITY
MEDICAL SCHOOL.

1. "Investigation into more effective treatment in acute and chronic gonorrhea," under the direction of R. L. Rigdon, M.D., Clinical Professor of Genito-Urinary Surgery, and A. B. Spalding, M.D., Professor of Obstetrics and Gynecology\$2,300
2. "The permeability of the meninges to anti-syphilitic drugs—an attempt to increase their permeability," under the direction of H. G. Mehrtens, M.D., Clinical Professor of Neurology... 2,300

3. "Investigation into more effective methods of treating syphilis," under the direction of H. E. Alderson M.D., Clinical Professor of Dermatology 2,600

Total\$7,200
UNIVERSITY OF MICHIGAN, COLLEGE OF
MEDICINE AND SURGERY.

1. "A research for an improved method of demonstrating the spirochæta pallida in human tissues," under the direction of A. S. Warthin, M.D., Professor of Pathology\$6,000

Council of National Defense.

Characterizing the work of the Volunteer Medical Service Corps and the Medical Section of the Council of National Defense as "a very striking demonstration of the American spirit," Dr. Edward P. Davis, president of the Corps, paid tribute to the patriotism of American civilian doctors at the final meeting of the Central Governing Board of the Corps held in Washington March 14, prior to the termination of its wartime activities April 1.

A report submitted at the meeting showed that nearly 70,000 applications have been received from physicians for membership in the Corps, of which 56,540 had been received and coded prior to the signing of the armistice, November 11, 1918. Qualifications of these civilian doctors, classified and coded on cards, will be placed in the library of the Surgeon General of the Army, where they will be accessible to all governmental departments for all time to come. With the approximately 40,000 medical officers additional, who are in the Army, Navy and Public Health Service, practically all the able-bodied, eligible doctors of the country will be listed, available for the nation's needs. Usually there are said to be about 150,000 physicians in the United States, but this total includes a large proportion of superannuated, disabled or ineligible.

Dr. Franklin Martin, Chairman of the General Medical Board of the Council of National Defense, expressed his warm appreciation of the co-operation he has re-

ceived from the medical profession of the country and his firm belief in the value of the records of the Volunteer Medical Service Corps.

Dr. Davis said, in part: "This Volunteer Medical Service Corps and the work of the Medical Section of the Council of National Defense has been a very striking demonstration of the American spirit in more ways than we have imagined. I have always thought of a remark made by the President when the whole thing was in full swing, just about the time the nation had gotten its stride. He said that the men who were staying in this country were having the hardest time. That was true. You take the medical men who actually went into service. Of course, some of them did office work in Washington, but the men whom I know who have been in the camps here—whether they got to Europe or not—say they have had the time of their lives.

"One man, my assistant, said: 'I am just coming back from a year's freedom from responsibility, except for the immediate performance of my duties.' Another man, who is probably the best X-ray man in the Army, said his career in the Army has been the happiest time he has ever known, because he has worked scientifically without interruption. They had the privilege of being free to concentrate their minds on duty, and I think the remark made by Dr. Studdiford in New York the other night is to the point—that there has not been in the past year in the practice of medicine in the United States one single easy, pleasant, satisfactory thing. He said he hoped he would never have to live to go through another such year.

"When you consider the burden thrown upon the profession of this country by the shortage of resident membership, taking away assistants, nurses, laboratory men; the influenza epidemic, with the consequent increase in morbidity and mortality, and the strain upon the population which is now showing itself—it has been a most hectic war season. I don't think any profession has met a similar crisis in civil-

ization as nobly as did the American profession, and no small part of the moral value and success of the profession was due to this Corps. The fact that we had a Corps where the men could record themselves who did not go to the front had an enormous moral value.

"I personally desire to testify to the pleasure it has been for me to do what I have done. And I have sincerely appreciated the honor which has been given me."

To about 13,000 doctors whose applications for membership in the Volunteer Medical Service Corps had been received before the armistice was signed but which had not been acted upon by their state committees, now dissolved, Dr. Davis is sending the following letter:

"From Volunteer Medical Service Corps,
Council of National Defense.

To: Applicants for Membership.

"1. With the cessation of hostilities subsequent to the signing of the armistice, the Council of National Defense, under which the Volunteer Medical Service Corps was organized, asked that the activities of that Corps be terminated, and Surgeon General Ireland of the Army requested that the valuable records of the Corps be given place in the Library of the Surgeon General where they will be maintained permanently for reference by the various Government bureaus.

"2. Your application for membership in this Corps, we regret to say, was not acted upon by your State and County Committees before those Committees were automatically released and, therefore, we are unable to complete your membership by furnishing you with the visible evidences of your tender of service, viz, the insignia and certificate of the Corps. We wish you to know, however, that your patriotic offer of service to your Government has been received and your qualifications as outlined on the Volunteer Medical Service Corps application blank have been transferred to permanent code cards which are to be preserved as an important record of the war.

"3. We also wish you to know that those

of us who have had the responsibility of organizing and enrolling the medical profession of the country appreciate the value of your offer of service and thank you for it from the bottom of our hearts. This includes the Secretary of War, who presides over the Council of National Defense which authorized the Volunteer Medical Service Corps; the Secretaries of the Navy, the Interior, Agriculture, Commerce and Labor, the members of the Council, and the President of the United States who appointed the Council of National Defense and who definitely approved the Volunteer Medical Service Corps in the following words: 'I am very happy to give my approval to the plans which you have submitted, both because of the usefulness of the Volunteer Medical Service Corps and also because it gives me an opportunity to express to you, and through you to the medical profession, my deep appreciation of the splendid service which the whole profession has rendered to the Nation with great enthusiasm from the beginning of the present emergency.'

"4. Finally, may I express to you on behalf of the Central Governing Board of the Volunteer Medical Service Corps its personal thanks for your generous response to its request for an offer of your services at a time when it appeared they would be so urgently needed by the nation.

"EDWARD P. DAVIS, M.D., President,
Volunteer Medical Service Corps."

Methodist Hospitals.

To alleviate human suffering and cure disease through the extension of its great system of hospital centers, now twenty-six in number, in countries where groups of millions of people are without adequate medical attention, the Board of Foreign Missions of the Methodist Episcopal Church will spend \$2,288,624 in building forty-five more hospitals and twenty-four dispensaries in foreign countries as a result of the Methodist Centenary movement to raise \$105,000,000 for world reconstruction.

This is an entirely separate venture

from that of the forty-eight hospitals maintained by the Methodist Episcopal Church in America through which pass annually over 90,000 patients. The property value of these institutions, coupled with their endowments, is \$15,626,343. In capacity they range from the Wesley Memorial Hospital in Chicago, caring yearly for about 7,000 cases, down to the Sunnyside Methodist Sanitarium for Tuberculosis at Silver City, N. M., accommodating seventy-five patients yearly.

The church has also just established a medical department to guard the health of its missionary workers.

Besides forty-five hospitals and twenty-four dispensaries, the Board will erect other buildings and doctors' residences, the whole costing \$1,513,930. It will draw into the service fifty-nine more missionary physicians and surgeons, thirty-two missionary nurses, and 166 native doctors, nurses and other medical assistants, the budget for staff and maintenance being \$774,694. The total for both buildings and staff is \$2,288,624.

In Mexico, where President Carranza has just given the Centenary plans his hearty approval, the board has at Guanajuato the only hospital in a population of 1,100,000. The nearest hospital is 200 miles away and the next nearest 400 miles distant. This work is to be strengthened.

The board will establish hospitals, nurses' training schools, and organizations of visiting nurses in the capital cities of five republics of South America. The state hospitals there are not adequate to care for ten per cent of the people.

A missionary doctor in Portuguese East Africa is the only medical man for an area containing three and a half million people. Sometimes six o'clock in the morning finds fifty patients eagerly awaiting attention outside the little hospital. Another doctor and hospital in Rhodesia are equally popular among the blacks. It is proposed to increase the hospitals from two to six, each with missionary physicians and an adequate staff.

In China the board has eleven hospitals

and two dispensaries, all overworked. When bandits scourge a district, they always spare the mission hospitals because of their reputation for healing the sick. Care of wounded during the Chinese civil war raised the estimation of the foreign doctors in the eyes of the people still higher. It is proposed to improve the staff and facilities of existing institutions, establish two additional hospitals and eleven dispensaries and, in association with other missions, man and equip medical schools for the training of Christian Chinese.

The Methodists will build a hospital for Mohammedans in Singapore, and erect nine hospitals on the various islands of Malaysia, the governments bearing part of the cost. They already have a hospital in Java and a doctor in West Borneo.

In the Philippines a medical station will be established at Apparri, Luzon, which will minister to 250,000 people who are within four days' journey by boat from Manila; while another station at Dagupan, the largest commercial center outside of Manila, will have a field of a million people.

There are many other phases of Methodist medical work, such as a leper home and Tuberculosis sanitarium in Africa, and three hospitals and a dispensary in India, which will be improved and developed.

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"Roosevelt Institute of American Family Life" Suggested.

A "Roosevelt Institute of American Family Life," to be developed in connection with the Eugenics Record Office of the Carnegie Institute at Washington, has been proposed to the Roosevelt Permanent Memorial National Committee by the Eugenics Research Association of Cold Spring Harbor, Long Island. Announcement of this project was made recently at the headquarters of the Memorial Committee at 1 Madison Avenue. The Eugenic Research Association which made the proposal owns eighty acres of land in Roosevelt's own voting precinct and has already laid the foundation for the study of the factors

controlling American family life. The plan calls for a memorial institute to be situated in the town of Oyster Bay. "This memorial institute," the Association declares, "will strive to advance those ideas of responsible and patriotic parenthood for which Theodore Roosevelt so valiantly battled."

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Mr. C. H. McDowell, director of the Chemicals Division of the War Industries Board during the war, and president of Armour Fertilizer Works for many years, has been chosen to act in an advisory capacity to Bernard Baruch on the American Commission negotiating peace in Paris. Mr. McDowell, who is en route to Paris where headquarters will be established, will work on the economic and after-the-war phases of the chemical and raw material problems. He is well known in chemical, agricultural and business circles throughout the country, has had a vast experience in chemical lines, and will prove a valuable aid to the committee.

The work in Paris, Mr. McDowell said, would be with the raw material side of the chemical problems of reconstruction, including dyes, ferro alloys, potash and agricultural chemicals, from a commercial and economic viewpoint. Mr. McDowell is going to Paris at the special request of Mr. Baruch, formerly chairman of the war industries board, who is now in Paris studying problems growing out of industrial reconstruction. He will be accompanied by Donald Riley, former Lieutenant Commander of the United States Navy, who has charge of the procurement of chemicals and explosives for the navy during the war. Mr. Riley is a son of Harrison B. Riley, president of the Chicago Title & Trust Company.

Mr. McDowell has been with Armour & Company for thirty-two years starting as a secretary to Mr. Philip D. Armour.

—————R—————

Honorably Discharged.

Among others who have "done their bit" and been recently discharged from the service is Barbitol-Abbott. The Abbott

Laboratories was one of the first to receive license from the Federal Trade Commission to make Barbitol (formerly known as Veronal) and shortly after they began producing it the government requisitioned practically every ounce of their growing output. This, of course, left none for the medical profession, which had hailed the original announcement that Barbitol was being made in America as one of the great chemical victories of the war. Now, however, the needs of the government are nearly filled, and the Abbott Laboratories announce that they are ready to meet all trade requirements. They furnish a pure product, every lot of which is standardized by tests on animals. There is considerable cause for gratification in the fact that a firm so distinctively American as the Abbott Laboratories has shown its equality with the best that Germany could produce. It is up to us also to encourage and support the products of such unquestionably American houses that there will never again be danger of foreign domination of the American chemical industry. Barbitol-Abbott is supplied in tubes of ten five-grain tablets, bottles of one hundred five-grain tablets, and powder in one-ounce bottles. Physicians desiring supplies will do well to take the matter up at once with their druggists, so that stock may be on hand when needed.

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Medical Examination of Employees.

Plans are being made by Armour & Company for the renewal of the medical examinations of 12,900 men and women working in the Chicago plant of the company. This means of safeguarding the health and safety of the Armour workers is not new but was discontinued during the war because of the urgency of orders placed to keep the fighting forces supplied with food and the enormous amount of extra labor needed.

Dr. Volney S. Cheney, chief surgeon, and his corps of assistants will have charge of the huge task. Every worker in the plant will be examined free of charge. The value of visiting a doctor at least once

a year to discover any defects in health which may easily be corrected by treatment is recognized generally by persons of means who visit their doctors regularly so that they may know in just what state of health they are. Armour & Company through their welfare bureau and their staff of doctors offer this service free to their many workers, and in case defects which have interfered with a man's work are brought to light, the man or woman will be transferred to some other task in the plant which, in the opinion of the medical men, they are better able to perform.

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Rupture of the Mediastinum During Artificial Pneumothorax.

Wilson and Jones report the following case from the New Mexico Cottage Sanatorium, Silver City, New Mexico: A woman with far advanced tuberculosis confined largely to the right side was treated with artificial pneumothorax, receiving injections every three to ten days from November to January. At each operation a small pocket was encountered and small injections produced high positive pressure so that no progress was possible. On January 23, 1918, an injection of air was attempted. About 150 cc. raised the pressure to high positive. A little more was given and a distinct snap was heard by the operator, nurse and patient. This was considered to indicate the breaking of an adhesion, for thereafter 350 cc. additional flowed freely into the chest with greatly reduced pressure. X-ray examination then revealed a small pocket of air on the right with firm adhesions between the lung and diaphragm. A larger pocket of air was to be seen on the left side and undoubtedly there was a communication between the right and left pleural cavities. The authors give their reasons as to why they consider the case one of air-communication through a ruptured mediastinum rather than one of double spontaneous pneumothorax; and mention that they have been unable to find the record of a similar case in the literature.

Tuberculosis Control in an Army Cantonment.

Major Wheaton describes the operation of a tuberculosis clearing station at Camp Grant, Illinois. This clearing station, established near the base hospital, largely solves the problem of careful re-examination in this camp. Upon arriving at camp the men were first examined by the general examining board and all manifest cases were promptly rejected. All suspected cases were then referred to the recall board which weeded out the active cases. Notwithstanding every precaution a certain number of healed, quiescent lesions reactivate. These men are sent to the clearing station by the regimental surgeon and if found manifestly tuberculous are sent to the tuberculosis ward of the base hospital for transfer to a government sanatorium. Many hundreds of soldiers were sent back to duty from the clearing station who would otherwise have entered the base hospital not manifestly ill with a diagnosis of tuberculosis, needlessly occupying bed space and taking up the time of surgeons that should be devoted to those manifestly ill and needing care. From July to October, inclusive, 753 men were examined at the clearing station while 209 X-ray examinations and 1,207 sputum examinations were made. Of the cases that were referred merely on suspicion of tuberculosis, 28 were diagnosed chronic active pulmonary tuberculosis at first examination.

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Strong National Organizations.

The Red Cross Society of Japan was organized in 1886 and now, with a membership of more than a million and a half and a splendid equipment, ranks as one of the foremost relief organizations. Always in the vanguard of humanitarian activities the Italian Red Cross was never stronger than it is today after the great struggle in which it played such a heroic part. At the end of 1918 the organization had more than 300,000 members. Its complete co-operation with the American Red Cross at a critical juncture of the war proved a

great help to the Allied cause.

France's Red Cross is made up of three distinct societies with a combined membership of about 250,000. It dates back to 1865. During the war it provided more than 50,000 nurses of all classifications and more than 1,400 auxiliary hospitals with a total of 117,000 beds. At the end of last July it had assets valued at more than \$21,000,000.

With headquarters in London and flourishing branches in Canada, Australia, India and South Africa, Great Britain's Red Cross met every test of the four-year conflict. It is one of the best organized and equipped among the societies that are planning for the future betterment of mankind. The organization has as its most valuable auxiliary the English society known as "The Order of St. John of Jerusalem," whose origin dates back to the days of the Crusaders.

Russia, up to the time of the empire's overthrow, had a capable Red Cross society, the efficiency of which was impaired to a great extent by the class troubles that eventually culminated in the present chaotic condition of the country. The Red Cross organizations of the Central Powers and their allies, Turkey and Bulgaria, are expected to join the movement.

As is pretty generally known, the German Red Cross and the Austria-Hungary Red Cross were organized along the same thorough lines as the military machines of those countries, being in fact part of those machines. Because of their complete domination by the military authorities they were regarded by the outside world as being out of harmony with the merciful spirit of the Red Cross. The relief organization in Turkey was known as "The Turkish Society of the Red Crescent," that in Bulgaria as the Bulgarian Red Cross. More than likely what is left of the organizations in these countries will be represented at Geneva.

Belgium has a fine Red Cross organization. So has Switzerland, the birthplace of the man who conceived the idea back of the Red Cross. The emblem of the Red

Cross is the Swiss flag reversed, a tribute to the country which has done so much to stimulate relief work throughout the world. The organization has about 50,000 members.

Holland, Denmark, Norway and Sweden to the north and Spain and Portugal in the south of Europe are all members of the Red Cross family. All the Balkan states have relief societies. China has had one since 1904. Mexico, Central America, South America—these countries have their quota of organizations.

Truly, the touch of the Red Cross makes the whole world kin.

—R—

Infection Through the Eye.

K. F. Macy, Fort Sill, Okla. (Journal A. M. A., March 1, 1919), calls attention to the likelihood of infection through droplet spray in the eye. The fact of the spread of the disease by projection of droplet conveyed germs has been demonstrated, and this method of infection is most probable during active and waking hours. The infection through the nares, which are less directly exposed owing to the downward direction of their outlet, and the mouth, which is not liable to receive droplets except when held open, is practically less possible than that due to spray droplets on the directly exposed 600 sq. m. of eye surface. When this is reached the germs can be carried into the lacrimal ducts to the nasal passages. Experiments are detailed by Maxcy showing how this process practically occurs. A suspension of *B. prodigiosus* could be instilled into the conjunctival sac and be recovered within from five to thirty minutes from the nasal passages. From this point the infective germs can be carried into the larynx and to the respiratory tract, or into the gastro-intestinal tract through the esophagus as well as be discharged through the mouth in the sputum. The gauze face mask protecting the nose and mouth, therefore, is not a complete protection, and the frequency with which respiratory infections are conveyed from one person to another amply warrants this possible route of contagion

as a formidable probability. It is impracticable, however, to use the gauze mask with very sick persons, and physicians and attendants should bear this fact in mind. Maxcy offers the following conclusions: "1. The eyes offer a relatively large surface area for the reception of droplets sprayed from the mouths of other persons. 2. An organism introduced into the conjunctival sac may be recovered from the nose in five minutes, and from the stool in twenty-four hours. 3. The upper respiratory tract of a person wearing a properly constructed mask may be infected by exposing the eye briefly to direct droplet spray. 4. This portal of entry is of importance in the transmission of acute respiratory infections."

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Focal Infections of the Eye.

J. G. Dwyer, New York (Journal A. M. A., Dec. 21, 1918), says that among the local infections due to intestinal toxins there are some of the eye due in all probability to absorption of such toxins. He was been studying the subject for two years, and the object of his article is to call attention to it. One difficulty is that the authorities are not agreed as to what the intestinal contents ought to be in general, but the author has come to look for certain main characteristics. Practically most authors admit that the normal feces is faintly alkaline to litmus. Dwyer has, however, found that with phenolphthalein the reaction is slightly acid. Keeping the three fundamental types of food, fats, carbohydrates and proteins, in mind, his guiding principle was to cut out of the diet those that were not assimilating; that is, the by-products of which are indol, skatol, and phenol. As regards the question of bacteria, the intestine normally carries many and various forms. Bearing in mind the work of other investigators, especially Metchnikoff, he gave his special attention to the colon bacillus, which appears in the intestine a few days after birth and is commonly found there during life. It is gram-negative, thus differing from the majority found there. In both acid and alkali-

line conditions of the contents of the intestines the colon bacilli were either absent or present in small numbers. It was always found that in highly acid or alkaline specimens the indol and skatol content was high, as was also the percentage of indol in the urine. The following methods were then adopted: In the highly acid specimen, an endeavor was made to alkalinize the contents by alkaline irrigations, and then practice colon bacillus transplantation, and giving a rather free diet, cutting out such foods as are not completely assimilated, such as meat. In the highly alkaline specimens irrigations with lactose were given, and then the colon bacillus was transplanted. At the same time the Bulgarian bacilli and lactose were given by mouth. Three cases are reported, two of them are iritis. In all three, benefit was obtained. He makes no claim to novelty in this work, but his results in sixty-six cases were striking, in the main.

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Treatment of Burns.

T. Sollman, Cleveland (Journal A. M. A., April 5, 1919), states that dichloramine-T has the real advantage of furnishing a continuous supply of the antiseptic agent and securing a continuous action over long periods of time. The solutions must be prepared with some care and must be fairly fresh, or else tested for the presence of available chlorin. It also causes considerable smarting and burning, which, however, disappears promptly and can generally be tolerated. It is liable to irritate the skin. Certain physical limitations are more serious in connection with burns. The large open surfaces require protection against irritation and access of air, and this the dichloramine-T-chlorcosane fails to furnish. On the contrary, the solutions are absorbed by the dressings, causing pain and injury when removed. These drawbacks are especially conspicuous in treating painful and slowly healing mustard-gas burns, which have to be protected in the ulcerated stage by thick petrolatum dressings, especially at night. These protect the bacteria as well as the tissues, and

delay healing. It was attempted to better matters, either by alternating the antiseptic and protective dressings, or by applying a petrolatum dressing to the wound after painting it with dichloramine-T-chlorcosane solution (generally 2 per cent strength). It was known, of course, that dichloramine-T is gradually destroyed by ordinary petrolatum, but it was hoped that this would be slow enough for some of the antiseptic to last from one dressing to another. This expectation was not realized, and a more detailed study resulted in the working out of a special petrolatum medium that is sufficiently compatible with dichloramine-T for surgical purposes. "Attention may be called to the fact that liquid and semi-liquid mixtures of petrolatum with active drug are not subject to the same limitations as is the incorporation of these drugs into solid paraffin. Solid paraffin prevents adequate contact of the mass of the antiseptic with the wound. On the other hand, the layers of liquid and semi-liquid mediums in contact with the wounds are continuously changed, so that good contact is secured." He describes experiments to determine the rate of the destruction of dichloramine-T in various solvents, and finds that an ointment of three parts surgical paraffin and seven parts liquid petrolatum has relatively little destructive action on dichloramine-T, and can be used as a protective on burns treated with dichloramine-T-chlorcosane solution, and even as a basis for a dichloramine-T ointment. Ordinary petrolatum, whatever its color, is very destructive of dichloramine-T and cannot be used with it. Liquid petrolatum can be used in emergencies as a vehicle for it, though it is inferior. Solutions of dichloramine-T in carbon tetrachlorid are very stable, while those in kerosene or in olive oil deteriorate very fast.

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Influenza and Pregnancy.

A statistical study of a large number of cases of influenza in pregnant women is published by J. W. Harris, Baltimore (Journal A. M. A., April 5, 1919). A ques-

tionnaire was sent out to all the physicians of the state of Maryland, to the members of the American Gynecological Society, the American Association of Gynecologists and Obstetricians, and to the local obstetric societies in four of the larger cities. Thirteen hundred and fifty cases were reported in full detail, and are used in this study. Of these, 971 were from the state of Maryland; hence the majority occurred under the same general conditions. Of the patients, 1,266 were white, eighty-two were negro and two were Japanese. The results of the study are given in tabulated form, each table being commented on in turn. It is assumed that the cases were all serious enough to require medical attention, and do not include many of those occurring in the first two months of pregnancy. "With these reservations, the results of the study are as follows: 1. Pneumonia complicated the influenza in about one-half of the pregnant women here reported. 2. In the cases complicated by pneumonia, about 50 per cent of the patients died, the mortality being somewhat greater during the last three months of pregnancy. 3. The gross mortality of all cases was 27 per cent. 4. Pregnancy was interrupted in 26 per cent of the uncomplicated cases, and in 52 per cent of the cases accompanied by pneumonia. In the cases ending fatally, abortion or premature labor occurred in 62 per cent. Thus, in 38 per cent of the fatal cases the patient died without interruption of pregnancy. 5. The mortality of influenza was considerably higher (41 per cent) in the cases complicated by abortion or premature labor than in those in which pregnancy was uninterrupted (16 per cent)."

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Influenza in Korea.

F. W. Schofield and H. C. Cynn, Seoul, Korea (Journal A. M. A., April 5, 1919), describe the pandemic of influenza in Korea during the month of September and later in 1918. The infection came from the north, along the line of the Southern Manchurian Railway, and was, they think, of European origin. The first cases were

seen in the latter part of September, and by the middle of October the epidemic was at its height, being greatly aggravated by unsanitary oriental conditions. The serious nature of the outbreak was due, as elsewhere, to the complications of bronchitis, bronchopneumonia and heart failure. The symptoms were those of ordinary influenza but exaggerated, and everything points to a droplet infection as the cause. In fourteen typical cases examined bacteriologically only three showed the presence of Pfeiffer's bacillus, and two out of these three were complicated with pneumonia. "The other eleven cases showed a variety of organisms. Pneumococci prevailed in three, almost a pure *Micrococcus catarrhalis* in one, and the others gave a variety of streptococci, gram-negative and gram-positive, diplococci, etc. In two cases a diphtheroid bacillus greatly predominated." Three cases of special interest are reported. One of these was in a man, a carrier of Pfeiffer's bacillus for over a month who came down with typical influenza two weeks after receiving influenza vaccine. Had the sputum in this case been examined at the time of the attack, Pfeiffer's bacillus would have gotten the credit. They discuss the evidence for and against the Pfeiffer bacillus. The highly contagious nature of the disease presupposes the concentration of the virus in large amounts in the sputum, which is not the case with the Pfeiffer bacillus. The comparatively small number of cases in which it is found is another fact against it, and in the above mentioned case the patient was the carrier of this organism before he caught the influenza from other members of his family. The absence of marked antibodies to this organism, except in cases where it has been isolated, is still another argument against it. The evidence for the Pfeiffer bacillus is its being more frequently found than any other one organism, and the absence of any evidence of a ultramicroscopic cause. Before the epidemic began, the influenza bacillus was a common parasite in respiratory infections. Some experiments with filtrates are reported, but do

not support the theory of a filtrable virus. Definite conclusions cannot be drawn and the etiology of the disease is still unknown. Further experiments with both filtered blood and secretions will be needed if we are to determine the possibility of a filtrable virus.

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Effects of Typhoid Fever and Antityphoid Immunization on Pulmonary Tuberculosis.

In the summer of 1917 a typhoid fever epidemic occurred at the Trudeau Sanatorium. Thirteen patients and two maids developed typhoid fever. Since the thirteen patients were all suffering from pulmonary tuberculosis in a more or less active form the opportunity was given to study the interacting effects, if there were any, between the two diseases. As soon as the presence of the epidemic was appreciated, antityphoid inoculation was performed on 124 patients at the sanatorium. The authors, Brown, Heise, Petroff and Wilson, report the results of their studies on these tuberculous patients who had typhoid fever or prophylactic inoculation, and the deductions to be drawn therefrom. Results are tabulated in five tables and detailed case reports of every typhoid fever patient were appended at the end of the study.

Among the more important conclusions worked out by the authors are the following:

Inactive pulmonary tuberculosis exerted no appreciable effects upon the course of the typhoid fever, but as the two deaths from typhoid fever occurred among those with active pulmonary tuberculosis, it appears possible that active pulmonary tuberculosis may influence the typhoid fever and render recovery less likely.

Typhoid fever does not influence inactive pulmonary tuberculosis and apparently also does not affect active pulmonary tuberculosis.

Antityphoid inoculations did not apparently influence the inactive pulmonary tuberculosis. No permanent untoward results followed in any case.

The immediate results of treatment in patients receiving antityphoid inoculations differed in no way from the immediate result obtained in two other years when such inoculations were not given.—American Review of Tuberculosis, February, 1919.

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Delayed Tetanus.

W. L. Whittemore, Shorncliff, Kent, England (Journal A. M. A., Dec. 14, 1918), reports two cases of tetanus, in which after apparent recovery there occurred, at a later date, similar though milder attacks of the same disease. These men were wounded, one three and one-half months before the onset, and the other nine months previous. In the second case, three months after the original wound was received, an operation was performed in the neighborhood of the healed wound which may have caused an earlier appearance of the disease. In both, local symptoms and signs appeared two and three weeks before the secondary generalized disease. Both patients were treated with antitetanus inoculations, both shortly after the original wound, and during the attack. Eye symptoms were present in both cases, and in one a bad keratitis, in the other iritis and conjunctivitis. Whittemore concludes from these cases that the incidence of traumatic tetanus may be markedly delayed, and that relapses may occur after such attacks. The premonitory symptoms are localized in the neighborhood of the wound. The relapses are not so long or severe as the original delayed attack, which may be followed by muscular symptoms for weeks and months, and these cases raise the question whether excision of the focus may not be advisable, even when there is no foreign body included, as a precautionary measure against tetanus.

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Value of Blood Urea.

A. E. Goldstein, Baltimore (Journal A. M. A., Dec. 14, 1918), reviews the literature of the blood urea test for the diagnosis of urologic conditions, and reports his own investigations, carried out practically along the same lines as those of



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Scherck and Gradwohl, the principal retention test employed being that of blood urea. Goldstein says that for the purposes of comparison and to demonstrate the value of this test in diagnosis and prognosis he has also employed the three following tests: (1) the urine urea test; (2) the phenolsulphonephthalein test, and (3) the ordinary chemical and microscopic examinations of urine (albumin, casts, etc.) The article is a lengthy one, for abstracting in detail, but the conclusions reached are substantially as follows: In blood urea we have a valuable retention test for the diagnosis and prognosis of urologic cases applicable to all. As a prognostic agent it is practically infallible. It is a simple procedure and can be used when other excretory tests, such as phenolsulphonephthalein, urine urea, etc., fail. When relative kidney function is desired, it should be used together with the excretory test. In a case of more than 1 gm. of blood urea per liter of blood, the prognosis should be considered grave and when less than 0.75 gm. as good. An oncoming uremia can be diagnosed long before the clinical signs appear, and before the excretory tests can give the information. Goldstein holds that its more general employment will decrease the percentage of mortality of the urologist and general surgeon. Three tables accompany the paper.

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Dr. Simon Flexner stated that for the present the disease should be viewed as of unknown causation. Its relation to other diseases, e.g., influenza and infantile paralysis, is merely conjectural. None of the European observers ascribe the cases occurring in their respective countries to influenza or other well known diseases, although the resemblance of the pathological lesions in the nervous system to those occurring in infantile paralysis has led to a discussion of the correspondence and difference of these two afflictions. It is highly important that the suspected cases of lethargic encephalitis should be studied, both clinically and pathologically. —New York Medical Journal.



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PRESIDENT'S ADDRESS

The Kansas Medical Society in the World War

W. S. LINDSAY, M.D., Topeka

Annual Meeting, Kansas Medical Society, Ottawa, May 7 and 8, 1919.

When the United States entered the war the Kansas Medical Society had approximately 1,400 members, including aged and infirm. Of these, 649 volunteered and were sworn into the United States service as medical officers. Of this number many went overseas and were engaged in active war duty. I have not been able to procure data showing the heroism and hardship, as well as efficient service, these men performed. Many of them are still away from their offices and families, doing their part in support of the military establishment of our country and receiving a salary insufficient to maintain themselves and their dear ones at home.

Casualties of the whole American Medical Service amount to 442, to March 13, 1919. The professional loss which our

members have sustained is, I think, worthy of mention. The practice of medicine is at best more or less evanescent, never static, and especially liable to disintegrate during the doctor's absence. Many of our men will return to realize not only the loss of time, but a scattering of their clientele, which will require much time and effort to collect. Military service is so different from civilian practice that much readjustment will be necessary.

The loyalty of our society was not all expressed by the men who entered actual military service. Our part in the Medical Section of the Council of National Defense is highly creditable. The many members who volunteered through the questionnaire sent to the doctor, and served as examiners on local and medical advisory boards and otherwise, will have besides the time-honored Caduceus in the form of a button, the consciousness of having contributed a valuable service to our country.

The following list of names and addresses is as nearly accurate as I have been able to make it:

Adams, Samuel, Niles
Adams, A. R., Easton
Adams, J. R., Soldier
Adams, E. V., Topeka
Adams, C. S., St. John
Adkins, E. M., Galatia
Agnew, T. M., Wichita
Alford, J. S., Independence
Allen, G. V., Topeka
Allen, L. G., Lenexa
Allen, G. H., Topeka
Alexander, H. A., Topeka
Annadown, P. V., Centralia
Anderson, B. A., Ft. Leavenworth
Anderson, B., Victoria

Anderson, G. M., Lincoln
Andres, P. C., Hays
Appleby, C. L., Peabody
Asbell, E. L., Kansas City
Atkins, Herbert, Pratt
Atkins, E. H., Hoisington
Austin, F. J., White Cloud
Baker, J. H., La Crosse
Baker, R. E. B., Belle Plaine
Bantleon, V. H., Kansas City
Barnes, H. M., Blue Mound
Barker, J. W., Chanute
Barker, J. A., Leavenworth
Barkers, O. O., Muscotah
Barney, L. F., Kansas City
Baxter, L. W., Columbus

Baily, S., Garden City
Beach, Mark, Clinton
Beiber, Karl, Tipton
Brady, W. R., Parsons
Bennett, R. M., Mound City
Bennet, C. C., Rantoul
Beyer, L. J., Little River
Beckner, E. J., Goodland
Belot, M. L., Clyde
Bealson, L. M., Ashton
Beveral, G. W. B., Alma
Bell, P. M., Wichita
Billings, A. E., Topeka
Bigelow, G. J., Caney
Bliss, C. J., Mayetta
Blake, C. D., Ellis

- Blouse, W. G., Centralia
 Boardman, W. E., Parsons
 Boyer, U. S., Ada
 Bover, L. J., Hutchinson
 Bowser, E. E., Parsons
 Boyce, S. F., Iuka
 Bowen, W. F., Topeka
 Boudreau, C. E., El Dorado
 Brown, E. G., Topeka
 Brown, A. L., Wichita
 Brown, C. E., Leavenworth
 Brown, L. T., Spearville
 Brown, W. T., Williamsburg
 Brickell, J. B., Americus
 Broderick, E. J., Dodge City
 Brookhart, H. H., Columbus
 Brookhart, W. H., Coldwater
 Brunig, H. R. D., Hillsboro
 Bribach, E. J., Atchison
 Brethour, G. E., Dwight
 Brittain, O. R., Salina
 Brubaker, C. F., McPherson
 Bundrant, W. C., Partridge
 Button, M. A., Topeka
 Burket, I. R., Ashland
 Bunten, J. C., Douglass
 Butler, W. L., Stafford
 Burr, W. B., Longton
 Caffey, H. B., Pittsburg
 Cahill, C. J., Topeka
 Callahan, W. P., Wichita
 Campbell, J. R., Coats
 Carlyle, W. L., Sabetha
 Carr, W. A., Junction City
 Carson, P. C., Ashland
 Cave, R. R., Manhattan
 Cave, F. C., Winfield
 Carter, F. F., Baileyville
 Carmichael, F. A., Osawatomie
 Caldwell, J. C., Wellington
 Castles, J. E., Lawrence
 Carey, F. S., Kansas City
 Chadwick, I. B., Tyro
 Chaney, W. C., Independence
 Chaney, J. W., Wichita
 Chambers, H. L., Lawrence
 Christman, Paul, Parsons
 Charles, H. L., Atchison
 Chapin, C., McCune
 Clark, Oscar, Victoria
 Clark, E. F., Mayfield
 Clark, H. L., LaCygne
 Clary, L. A., Hutchinson
 Clayton, E. H., Arkansas City
 Close, J. B., Marysville
 Cludas, A. L., Minneapolis
 Clasen, A. C., Rosedale
 Coe, W. B., Waterville
 Core, L. M., Galva
 Cohen, Felix, Kansas City
 Cox, S. C., Nat'l Mil. Home
 Cox, S. L., Iola
 Coleman, T. A., Medicine
 Lodge
 Cooke, E. D., Topeka
 Cook, J. D., Topeka
 Corbett, O. J., Emporia
 Coplan, L. S., Wellington
 Coburn, C. E., Kansas City
 Combs, J. W., Brownell
 Cobean, H. L., Wellington
 Coffman, J. F., Marion
 Cole, C. W., Norton
 Cornell, J. C., Parsons
 Crabb, J. A., Topeka
 Crawford, J. R., Tonganoxie
 Crittenden, A. L., Wichita
 Cronk, C. F., Anthony
 Culver, C. C., Burlington
 Cullem, A. B., Garnett
 Culbertson, W. F., Kansas
 City, Missouri
 Davis, H. W., Little River
 Davis, A. P. (colored), Kan-
 sas City
 Davis, G. W., Ottawa
 Davis, R. G., Kansas City
 Davis, W. L., Corning
 Davidson, H. T., Wichita
 Davidson, C. O., Garden City
 Dawson, A. M., Topeka
 Day, B. H., Hugoton
 De Mand, J. W., Lincolnville
 De Mott, C. W., Independence
 De Pew, F. J., Howard
 Dixon, O. J., Mound Valley
 Dillingham, W. R., Sabetha
 Dieter, C. A., Hope
 Dillon, J. C., Portis
 Dingus, J. C., Mound City
 Dodds, D. C., Summerfield
 Donnell, J. B., Kingsley
 Downing, R. H., Wellington
 Downs, J. M., Ellsworth
 Doherty, W. T., Wichita
 Drake, Emory, Natoma
 Dreher, H. S., Waldo
 Duncan, E. C., Fredonia
 Earp, R. B., El Dorado
 Ebright, E. D., Wichita
 Edwards, J. B., Garden City
 Edmiston, R. M., Americus
 Egloff, Geo., Towanda
 Ellis, F. G., Frederick
 Elliot, C. E., Ft. Riley
 Engberg, A., McPherson
 Ensign, C. T., Lawrence
 Ernest, F. J., Topeka
 Erickson, O. L., Topeka
 Evans, C. S., Hutchinson
 Eye, B. F., Kansas City
 Fall, N. B., Gueda Springs
 Farley, J. A., Topeka
 Fast, W. K., Atchison
 Faust, J. W., Kansas City
 Ferguson, C. S., Atchison
 Fegtly, A. W., Douglass
 Finney, Guy, Wamego
 Finney, J. A., Wamego
 Fitzpatrick, C. M., Salina
 Fisher, C. S., Fontana
 Fisher, R. S. C., Wichita
 Fisher, L. S., Raymond
 Flack, F. L., Coffeyville
 Floersch, M. A., Topeka
 Fleming, W. S., Ness City
 Forbes, D. M., Kansas City
 Fortney, A. M., De Soto
 Forney, O. L., Hutchinson
 Frazer, B. T., Osawatomie
 Fryer, J. L., Leavenworth
 Fry, C. S., St. George
 Frost, Earl, Wichita
 Fulton, L. A., Kansas City
 Gartner, W. A., Troy
 Gage, G. R., Hutchinson
 Garlinghouse, O. L., Iola
 Gates, W., Kansas City
 Garrison, G. B., Eureka
 Gafford, G. M., Kingsley
 Gardner, A. E., Wichita
 Gibbs, O. M., Greenfield
 Gist, E. H., Beattie
 Glover, H. M., Newton
 Goodman, A. R., Topeka
 Goss, H. L., Horton
 Gore, L. M., Gore
 Gootee, H. W., Topeka
 Greening, W. P., Wichita
 Grove, J. L., Newton
 Graham, J. W., Highland
 Gray, G. M., Kansas City
 Greenwood, Thos., Circleville
 Grieder, W. H., Topeka
 Griggs, E. E., Garden City
 Grissell, W. S., Rawson
 Grissom, C. B., Syracuse
 Guy, W. P., Winfield
 Hatcher, A. R., Wellington
 Haughey, G. K., Wakeeney
 Haughey, L. E., Concordia
 Hamilton, G. L. A., Kan. City
 Hall, M., McPherson
 Hall, C. W., Hutchinson
 Hardesty, H. O., Jennings
 Harker, H. J., Horton
 Hassig, J. F., Kansas City
 Hartman, R. C., Newton
 Hartman, W. V., Pittsburg
 Hawke, C. C., Winfield
 Hawk, Benj., Anthony
 Haggart, Alex., Ottawa

- Haggaman, C. V., Scandia
 Harlin, R. I., Erie
 Haws, Frederick, Russell
 Hahn, Milton, Arkansas City
 Hammel, S. A., Topeka
 Hammer, J. E., Hardtner
 Harvey, L. S., Council Grove
 Harvey, C. C., Emporia
 Harvey, F. E., Minneapolis
 Hawthorn, H. B., Palmer
 Haerle, H. H., Niles
 Hay, A. D., Cherokee
 Hayes, C. F., Arlington
 Haynes, E. B., Madison
 Haynes, H. A., Sabetha
 Harper, H. J., Horton
 Haldeman, J. H., Paola
 Hamstid, I. E., Burrton
 Hanson, J. H., Elkhart
 Hares, F. B., Russell
 Hedge, M. O., Kansas City
 Hewitt, J. E., Ft. Riley
 Hendricks, H. L., Climax
 Heuschele, W. H., Ft. Riley
 Henderson, R. C., Pittsburg
 Henderson, L. E., Coyville
 Hesner, G. E., Topeka
 Hensley, C. M., Topeka
 Hertzler, R. H., Newton
 Heidrick, D. L., Welda
 Hickey, F. R., Chanute
 Hinshaw, L. M., Bennington
 Hissem, R. W., Wichita
 Higgenbotham, G. W., Wichita
 Hindman, J. H., Humboldt
 Hobson, G. H., Kansas City
 Horner, T. E., Atchison
 Hockaday, J. A., Santanta
 Hobart, W. K., Topeka
 Hood, T. A., Garnett
 Horn, M. H., Morrowville
 Horn, H. W., Wichita
 Hombach, F. J., Kansas City
 Hodges, W. A., Severy
 Hoggart, Alex, Ottawa
 Hoffman, R. L., Ellsworth
 Hodgson, J. E., Downs
 Holland, D. A., Cambridge
 Hudiburg, W. S., Independ'ce
 Hudson, H. H., Newton
 Hunt, W. D., Emporia
 Hunsberger, H. G., Mt. Hope
 Hunter, W. S., Norton
 Isenburg, B. A., Alton
 Iliff, W. H., Crestline
 Ingels, A. B., Larned
 Irland, E. M., Coldwater
 James, R. W., Winfield
 Jackson, D. O., Manchester
 Jennings, Geo., Simpson
 Jones, C. W., Olathe
 Jones, G. I., Ft. Leavenworth
 Jones, A. D., Wichita
 Jones, P. A., Lenexa
 Johnson, F. T., Jr., Elmdale
 Johnson, E. H., Peabody
 Johnson, E. W., Coffeyville
 Jordan, B. H., Medicine L'ge
 Jury, H. W., Claflin
 Kalbfleisch, E. L., Newton
 Kennedy, Francis, Norton
 Kennedy, J. G., Altoona
 Keller, W. C., Athol
 Kellam, S. H., Cherryvale
 Keefer, M. H., Kansas City
 Keith, E. R., Leavenworth
 Kerr, C. C., Lecompton
 Kidd, N. A. Jr., Ellis
 King, H. W., Kansas City
 King, G. A., Maple Hill
 Kisecker, D. E., Caldwell
 Kingsley, G. A., Kansas City
 Knappenberger, G. E., Man-
 kato
 Knowles, H. P., Sterling
 Knisley, A. L., Liberal
 Koch, A. G., Hutchinson
 Koentz, H. P., Onaga
 Koger, R. G., Norwich
 Koons, F. W., Nickerson
 Kreger, G. C., Richmond
 Kraft, F. E., Nat'l Mil. Home
 Lawrence, A. K., Wichita
 Landis, G. A., Parsons
 Langworthy, J. H., Leav'w'th
 Lardner, J. C., Ft. Scott
 Lapat, W., Larned
 Layton, R. W., Kansas City
 Lambeth, G. S., Bronson
 Lerrigo, C. H., Topeka
 Lewis, A. J., Council Grove
 Lewis, W. J., Colby
 Lewis, C., Kansas City
 Lencyer, A., Aurora
 Lindsay, M. K., Topeka
 Lightner, O. N., Benton
 Liston, Odus, Hudson
 Lind, A. J., Kansas City
 Little, A. W., Kansas City
 Little, G. R., Wichita
 Lightfoot, E. C., Mineral
 Loveland, F. L., Topeka
 Longnecker, C. W., Kingman
 Longnecker, O. M., Rosedale
 Lowis, W. J., Colby
 Lodge, E. A., Parsons
 Logsdon, R. O., Wichita
 Lovene, A. W., Burdick
 Lose, F. D., Madison
 Lowe, O. C., Paola
 Lull, C. C., Topeka
 Lyon, F. P., Wichita
 McBride, J. S., Lyons
 McCormick, G. C., Baxter
 Springs
 McCool, S. A., Neosho Falls
 McCarthy, H. E., Kansas City
 McCullough, W. A., Delavan
 McCreery, G. R., Whiting
 McGill, J. F., Ft. Scott
 McGaughey, H. B., Jamest'n
 McGuire, C. A., Topeka
 McGinnis, S. S., Dighton
 McGlaughlin, J. A., Greens-
 burg
 McGee, C. J., Leavenworth
 McGonigle, G. L., Bucyrus
 McKinney, R. B., Augusta
 McKeehan, L. P., Atchison
 McKinnon, J. C., Caldwell
 McKinlay, C. A., Wichita
 McManis, J. E., Havensville
 McNair, C. F., Topeka
 McNaught, J. F., Girard
 McFarland, C.R., Blue Rapids
 Mabie, L. D., Kansas City
 Mallison, S. N., Canton
 Manson, D. W., Burlington
 Marrs, E. A., Moline
 Marchbanks, H. E., Pittsburg
 Matassarini, Leon, Wichita
 Maness, W. G., Preston
 Mathews, J. R., Manhattan
 Matz, P. B., Kansas City
 Maxson, J. C., Corning
 May, J. W., Kansas City
 Mann, F. P., Valley Falls
 Manson, D. W., Burlingame
 Marks, J. M., Valley Falls
 Mason, B. B., Grenola
 Mason, K. P., Cawker City
 Mayfield, C., Hutchinson
 Martin, S. H., Cambridge
 Martin, W. M., Wellington
 Martin, E. N., Clay Center
 Martin, C. J., Cullison
 Mayer, H. M., Ellsworth
 Mayer, B. H., Peabody
 Maggard, D. I., Wichita
 Mahaffy, G. C., Ottawa
 Makins, H. M., Abilene
 Meade, F. K., Hays
 Melencamp, N. E., Dodge City
 Melton, D. W., Preston
 Menninger, K. A., Topeka
 Meyers, S. M., Potter
 Myers, E. A., Wakefield
 Myers, Grant, Benton
 Mielke, C. H., Alma
 Mitler, C. M., Oakley
 Missildine, J. G., Parsons
 Millard, S. T., Topeka

- Michenor, W. E., Ottawa
 Miller, Frank, Wichita
 Miller, Milton, Topeka
 Miller, N. D., Topeka
 Miller, W. P., Kan. City, Mo.
 Miller, R. H., Greensburg
 Mills, L. D., Greeley
 Mills, C. J., Lebo
 Middlekauf, C. J., Hays
 Milne, L. S., Kansas City
 Mitchell, W. I., Wichita
 Moffatt, E. J., Clyde
 Moore, J. M., Madison
 Moore, O. O., Topeka
 Moore, D. J., Idana
 Morris, Clyde, Kansas City
 Mosley, C. L., Hepler
 Morgan, E. C., Clay Center
 Morgan, D. L., Emporia
 Moses, H. N., Salina
 Mowery, W. E., Salina
 Morton, W. R., Green
 Munford, R. H., Dodge City
 Munford, D. C., Montezuma
 Mundell, W. N., Hutchinson
 Murdock, Sam, Jr., Sabetha
 Myers, S. M., Potter
 Naismith, Jas., Lawrence
 Nash, A. R., Parsons
 Naylor, N. E., Centropolis
 Nesselrode, C. C., Kansas City
 Neptune, J. W., Salina
 Newton, Malcolm, Lincoln
 Newman, M. C., Toronto
 Nevitt, R. R., Mildred
 Nichols, R. T., Liberal
 Nichols, W. J., Pittsburg
 Nienstadt, W. F., Hartford
 Nixon, W. A., Great Bend
 Nixon, J. W., Girard
 Norman, W. G., Cherryvale
 Nossman, A. H., Whitewater
 Nyburg, M. O., Ashland
 O'Connell, J. H., Topeka
 O'Conner, T. A., Topeka
 O'Donnell, F. W., Junct'n C'y
 O'Leary, A. J., Burr Oak
 Oechsli, A. B., Stockton
 Orr, W. E., Arma
 Osburn, W. F., Parsons
 Owen, A. K., Topeka
 Owensby, O. M., Puttsburg
 Ott, L. S. S., Topeka
 Parker, H. J., Hutchinson
 Parker, C. A., Maize
 Patterson, P. M., Kansas City
 Payne, O. C., Humboldt
 Parmer, W. R., Kansas City
 Palmer, W. C., Hiawatha
 Padfield, E. G., Salina
 Parrish, W. A., Mulberry
 Page, Willifred, McCracken
 Pattison, J. F., Augusta
 Pearl, F. A. (colored), Atchison
 Petty, C. N., Altamont
 Pettet, J. D., Arcadia
 Pettet, P. A., Paola
 Peterson, D., Latham
 Peppers, J. L., Newton
 Phares, W. A., Wichita
 Phillebaum, J. C., Irving
 Phillips, Carl, Lawrence
 Pierce, L. J., Englewood
 Pickler, R. S., Beloit
 Poston, W. O., Quenemo
 Porter, Geo., Centerville
 Poultre, F. G., Horton
 Praither, B. T., Peabody
 Prout, W. S., Concordia
 Preston, R. O., Meriden
 Purves, G. K., Wichita
 Quiring, W. O., Shawnee
 Randolph, J. F., Belle Plaine
 Ransom, J. L. (colored), Topeka
 Radfield, E. G., Salina
 Ramey, W. G., Protection
 Ragan, R. E., Spring Hill
 Randall, C. L., Neodesha
 Reeves, E. A., Kansas City
 Ressler, C. E., Anthony
 Reese, Hal, Thayer
 Reed, W. W., Blue Rapids
 Reid, J. T., Iola
 Rhodes, W. L., Kansas City
 Richmond, Thos., Kansas City
 Riddell, J. D., Salina
 Rinehart, J. H., Quinter
 Risdon, J. W., Leavenworth
 Riley, B. R., Benedict
 Richert, H., Goessel
 Ross, C. E., Wichita
 Robison, Norval, Bison
 Robinson, C. W., Atchison
 Robinson, P. W., Osawatomie
 Robinson, W. F., Eudora
 Rodda, E. D., Arma
 Russell, M. F., Great Bend
 Rudolph, J. T., Belle Plaine
 Rudback, John, Seneca
 Rushton, J. S., Morrill
 Ruth, G. D., Mound Ridge
 Sander, C. E., Rosedale
 Salisbury, H. T., Burlington
 Sams, L. V., Topeka
 Schlegel, E. H., Wichita
 Schwartz, C. W., Topeka
 Scales, H. L., Hutchinson
 Schaffer, Frank, McLouth
 Scott, J. R., Newton
 Scott, A. B., Bucklin
 Scates, E. R., Kansas City
 Schroder, L. M., Kingsley
 Seehorn, N. A., Hutchinson
 Seydell, E. M., Wichita
 Settle, J. A., Reading
 Sharp, E. A., Kansas City
 Shawhan, R. C., Nat'l Military Home
 Shelton, F. W., Independence
 Shaw, J. C., Holton
 Shull, W. I. H., Topeka
 Sheldon, F. B., McDonald
 Shelley, A. A., Galena
 Sherman, J. N., Thayer
 Shepard, C. O., Independence
 Sheppard, C. E., Larned
 Sharpe, Elwood, Paris Island, S. C.
 Simpson, L. I., Moran
 Simpson, M. B., Jewell City
 Skates, H. R., Baxter Sp'gs
 Slayton, F. H., Wichita
 Smith, H. H., Highland
 Smith, D. H., Richmond
 Smith, C. H., Pittsburg
 Smith, H. D., Washington
 Smith, L. T., Newton
 Smith, W. F., Atchison
 Smith, D. C., Radley
 Smith, J. E., Kansas City
 Smith, L. A., Lawrence
 Snyder, H. G., Seneca
 Soering, J. W., Norcatur
 Springer, R. W., Pretty Prairie
 Speer, W. L., Clay Center
 Spake, L. B., Kansas City
 Speak, R. L., Kansas City
 Stuckey, H. W., Ft. Riley
 Stephens, C. B., Waldron
 Steadman, L. S., Junction C'y
 Stockton, M. L., Gridley
 Sterett, D. R., Leavenworth
 Stolenberg, W. R., Kingsley
 Stewart, J. G., Topeka
 Stewart, R. B., Topeka
 Sutcliffe, J. S., Iola
 Sutton, J. M., Lincoln
 Swenney, R. W., Rosedale
 Swab, C. M., Haddam
 Swails, J. G., Wathena
 Swartz, C. W., Topeka
 Taylor, E. C., Pretty Prairie
 Taylor, F. B., Leavenworth
 Taylor, R. A., Meriden
 Taggart, H. H., Wichita
 Terry, H. H., Fort Worth
 Tenney, E. S., Ft. Warren
 Tenney, E. H., Kansas City
 Thumes, G. W., Winona
 Thacher, G. I., Waterville

Thomas, B. D., Shawnee	Walker, G. R., Iola	Williams, A. P., Neodesha
Thomas, C. A., Edna	Walker, J. F., Wichita	Wilson, H. W. (colored), Salina
Theis, P. F., Arma	Walker, W. H., Kansas City	Wilhoit, J. C., Manhattan
Tinder, J. W., Parsons	Ward, R. C., Scandia	Wilkinson, H., Kansas City
Tinney, R. M., Norton	Wagner, L. S., Florence	Wilmoth, W. L., Denison
Tolle, C. E., Seneca	Waite, G. R., Kiowa	White, M. L., Topeka
Tomlinson, L. M., Harveyville	Watts, V. E., Smith Center	White, F. W., Emporia
Tooley, M. C., Schofield Barracks, F. H.	West, J. W., Narka	White, E. E., Stockton
Tooley, G. E., Washington	Webb, J. A. H., Stafford	White, G. R., Kiowa
Trueheart, M., Sterling	Webb, H. M., Humboldt	White, Myron, Coffeyville
Trump, F. A., Ottawa	Wentworth, J. L., Ark. City	Wheeler, L. J., Ellenwood
Turner, A. J., Garnett	Wesley, P. F., Haviland	Whitaker, W. O., Wichita
Turner, J. W., Ft. Leavenworth	Wedel, A. J., Hesston	Work, J. L., Topeka
Tugg, C. W., Great Bend	Wehe, W. A., Toronto	Wrightman, F. E., Sabetha
Ungles, J. B., Langdon	Welch, W. L., Hazelton	Wright, H. W., Enterprise
Updegrove, W. H., Pittsburg	Welch, Jas., Herington	Wyatt, C. A., Wakarusa
Van Deventer, R. W., Wellington	Weathers, Bahnson, Oawatomie	Yates, R. C., Vinland
Van Duyn, A. H., Hill City	Weaver, Ross, Concordia	Yound, R. C., Summit
Venard, J. S., Ness City	Weisgerber, A. L., Perry	Young, W. H., Fredonia
Vermillion, E. L., Kan. City	Wiedling, W. H., Topeka	Young, R. C., Arkansas City
Vincent, H. A., Perth	Winslow, G. H., Grainfield	Yoosuf, A. A. K., Worcester
	Withams, J. O., Emporia	Zugg, C. W., Great Bend
		Zink, Clyde M., Wellington

District Board Work from a Doctor's Standpoint

J. T. AXTELL, M.D., Newton, Kan.

Read at the Annual Meeting of the Kansas Medical Society, Kansas City, May, 1918.

On the sixth day of April 1917, the United States of America declared war against Germany. The events which led up to this declaration, the murder of innocent women and children by the sinking of the Lusitania and other ships on the high seas—the international highways where we had a perfect right to sail—are matters of history and do not come within the scope of this record. It is interesting, however, to remember that in 1812 we fought for this principle and won, and that if we should give up this right we could probably never assert it again, and the loss of the right to the seas and the markets of the world would mean financial panic and ruin.

On the 18th of May, 1917, the Selective Service law went into effect. Under this law all males between the ages of 21 and 31 were required to register, stating their names, ages, occupations, whether single or married, their nationality, etc. This registration took place on the fifth day of June, 1917.

On June 21 a local board for each county was appointed for the purpose of classifying all registrants within the county. These boards usually consisted of the county clerk, the sheriff, and the county physician.

On July 20, 1917, in Washington, D. C., under the personal direction of President Wilson, the drawing of all registered men took place. This was a human lottery and established what are called "order numbers" and each man is supposed to be called for service, other things being equal, according to this order number.

On July 20 Governor Capper, acting under the direction of the President of the United States, created two appeal boards in the State of Kansas. These were known as the First and Second District boards. The First District board included the First, Second, Third and Fourth Congressional Districts. The Second District board included the Fifth, Sixth, Seventh and Eighth Congressional Districts. On each district board there was supposed to be an attorney or a representative of the law, one man to represent agriculture, one to represent industry, one to represent manufacturing, and one physician. The first members of the First

District board were F. C. Coburn of Topeka, Hugh Farrelly of Chanute, G. E. Blakely of Emporia, E. E. Brewster of Leavenworth, and our Dr. S. J. Crumbine of Topeka. Later Dr. Crumbine gave up his place to Dr. W. S. Lindsay of Topeka, who is the present medical member of the board. Other changes were made until only one of the original members, G. E. Blakeley, remains on the board. The First District board made its headquarters in Topeka.

On the Second District board were appointed Judge F. C. Price of Ashland, W. F. Benson of El Dorado, Alfred Docking of Manhattan, A. J. Johnson of Wichita, and the writer. No changes have been made in this board since its organization. The Second District board met in Wichita on July 30, 1917, and made Wichita its place of headquarters.

On the sixth day of August, 1917, there was held in Topeka a joint session of the two district boards, called together by the Governor for the consideration of harmonious methods and rules of action on such questions as dependency, agriculture, industry, and physical examinations. On the thirteenth day of August the Second District board began its regular work in Wichita and has been in almost continuous session since that day.

Over 40,000 cases have been examined by the Second District board, besides many re-examinations. The work has been difficult and trying. The hours have been long. The board usually began work at 8 o'clock in the morning and worked until 12, began again at 1 P.M. and worked until 6, and very often met again in the evening for several hours work, and very often worked on Sunday in order to get the number of soldiers that were required by the War Department. Members of this board left their homes and business interests, in many cases involving thousands of dollars of loss, and worked for the Government, practically without remuneration—but I believe that every member of the board, when he thought of his home interests and was so tired of the uncon-

genial work that he felt like bolting, usually thought of the boys "over there" in the trenches, risking their lives as well as giving their time, and he buckled up his belt another notch and thought that simply nothing he could do should be considered a sacrifice.

On the fifth day of September, 1917, the first draft was made, which was a call for 5 per cent of the quota which had been assigned to each county and was made from the selected men who had been passed upon by the boards. On the 19th of September, 40 per cent were called, and on the third of October another 40 per cent called. On October 18 the boards were asked to select and certify the last 15 per cent, but probably because of lack of facilities for caring for them, this 15 per cent was not really called out until April, 1918.

Under the first work of the boards, a man was either selected and certified for service or he was discharged or exempted. There were no half-way measures and there was no selection into classes. On December 15, 1917, at noon, all discharges were annulled and questionnaires were prepared which made a classification of all men, not already inducted into the service, into five classes, and each class has numerous subdivisions represented by letters A, B, C, D, etc. It is understood and expected that no one will be called from Class 2 until Class 1 is exhausted, and so on down the line.

These questionnaires were finally ready and their mailing began on the 15th day of December, 1917, and 5 per cent were mailed each day for twenty days. Each questionnaire was divided into twelve series. Series 1, regarding age, occupation, education, etc.; Series 2, physical fitness; Series 3, legislative, executive and judicial officers; Series 4, ministers of religion; Series 5, divinity students; Series 6, military or naval service; Series 7, citizenship; Series 8, officials, federal employes, pilots and mariners; Series 9, religious conviction against war; and Series 10, 11 and 12, dependency, industrial and agricultural

occupations. These last three were where the great work of the local and district boards was found.

The medical work of the district boards was not very great, although there were constantly questions arising that only a doctor could answer or decide. A large part of the doctor's time on the boards, however, had to be devoted to the classification of registrants. In the early workings of the board, medical appeals were taken from the local boards and applicants were examined by the district boards or sent to physicians appointed by the district boards in different parts of the state. Under this system there were two physicians on each local board, one—called the consulting surgeon—acting only in an advisory capacity and examining only applicants who were rejected by the local board physician.

After the questionnaires were out but one physician was left on the local boards, and scattered over the state about fourteen medical advisory boards, of five members each, were created. It would be interesting, I think, to hear from some of the medical members of the advisory boards. If an applicant was accepted on physical grounds by the local physician, he could appeal to the nearest medical advisory board, or he could be sent to the medical advisory board by the government, in which case his expenses were paid to and from the board. Under the questionnaire no physical examinations were made by the district boards and their duties were only to pass on appeal cases from the local and advisory boards.

It is the theory of the Selective Service that every man is in the service of the government and owes everything to the government and his classification is for the purpose of determining where he can be the most benefit to his country. A man is not left on the farm because it is an injustice to him to take him from the farm, but only on the theory that he is worth more to the government there than he would be in any other service.

If one saw nothing but the classifica-

tion of questionnaires and the usual routine work of the district board, he would get a very poor opinion of the patriotism of Kansas people. It seemed to us that every man was trying by every possible means to evade military service. Exemption was claimed on every possible ground and appeals were taken at every opportunity where the classification did not suit the registrant. We had "conscientious objectors" who claimed that the creed of their church would forbid them to participate in war in any form, but it was a question in most cases whether the principal objection did not come from a great, big, yellow streak. In justice, however, it should be said that the conscientious objection was much more pronounced among the fathers and mothers than it was among the boys themselves.

We had applications for deferred classification in agriculture from boys who not only were not raised upon a farm but had never spent a day of their lives in working on a farm, and yet could make out a very good case where their parents happened to own a piece of land. In most cases these frauds were detected and the applicant placed where he belonged, in Class 1, Division E.

A fine point in classification came in distinguishing between industry and commerce. Creameries, flouring mills and such industries, where necessary changes were made in food products, were protected, while commerce—the simple buying and selling of products without change, such as grocery stores, merchandise stocks of all kinds, and even banks, were not protected. Many a grocer and dry goods merchant and bank cashier hoped he could be considered of more importance to the government in his business than in service abroad, but this was not according to rule, and he was promptly placed in Class 1, Division F.

Fathers and mothers brought their great stalwart sons, claiming exemption or deferred classification on all kinds of grounds, and the excuses they made were very often ludicrous. One man asked for

exemption for his son because he himself had but one eye, although there was nothing to show that his other eye was not good and he could perform as much work on the farm as any of his neighbors. One man claimed he had rheumatism so badly that he could not work and he walked doubled up and limping. When I shook hands with him I held his hand a little while and opened up the palm, which was thick and hard and horny from toil, and I said, "You poor man, just see how hard you have to work," and he almost burst into tears and said, "Yes, Doctor, I just have to work from morning until night, as hard as I can, I work all the time," and yet he was claiming exemption for his son on account of his inability to work on the farm.

One man appealed that his hired hand should be left with him as he had been working for him for three years and had never yet missed a chore-time. The board thought that such fidelity and attention to business on the part of the young man showed that he would make a very valuable soldier and he was promptly put in Class 1. One boy 21 years of age claimed he had been "manager" of his father's farm for fifteen years, and it was our opinion that he might become a General in a short time, if given an opportunity. The number of boys of about 21 years of age, in Kansas, that are "managers" of their fathers' farms is very remarkable, as disclosed by the claims made to the local and district boards. The physical condition of the fathers in Kansas, as shown by the questionnaires made out by their loving sons, is something deplorable. If you were to accept the evidence presented in this way, you would conclude that there was scarcely an able-bodied father in all the country. They were never able to more than just "chore around" while the 21-year-old boys did all the work. I am sure the State Board of Health must take this matter up and look into it and see if something cannot be done for this spavined lot of middle-aged men.

One man appealed to the district board,

from the findings of the local and medical advisory boards, on physical grounds, claiming that he had not had a thorough physical examination. He stated in his appeal that the board should have allowed him to hop 100 times before examining his heart, and that, as a matter of fact, they only made him hop 25 times, and he brought witnesses to prove how careless the medical advisory board had been. It was the opinion of the district board in this case that this man should be allowed to hop just as many times as he wished and he was advised to "hop" into the service as soon as possible.

But there is another side to this picture. There were many examples of readiness to enlist. A number wrote on their questionnaires, "Rearin' to go." Many men answered the question, "State why you cannot be easily replaced by another," "There is no reason on earth," and in such cases the district board always took the same view. One man answered the question, "State fully the actual condition which would result from your removal," by saying, "I think it would be ideal." We thought so, too. Six different boys, who were turned down for physical defects, reported to the Axtell Hospital for surgical work to enable them to pass the examination and enter the army. Each was operated on, his defect remedied and every one of them joined the service, most of them writing nice letters thanking us for what we had done for them. Hundreds of young men waived all claim of exemption and were anxious to get off in the first contingent. Many tried to trade with brothers and friends to get earlier into the war game, but there is no such thing as substitutes.

However, it was always refreshing to get into one's home town and see the Red Cross workers, the War Savings Stamps salesmen, the Liberty Loan drives, and see the parades and hear the bands play; to see the crowds that would gather at public meetings; and to notice this improvement from month to month, showing without any doubt that our people are getting

thoroughly warmed up, and warmed through and through, and that they are taking hold of this matter in real earnest. We are not really a nation of slackers, but we are red-blooded, wide-awake men and women, who love our country, who love freedom and democracy, and are willing to spend our last dollars—and our lives, if necessary—in this great world struggle for liberty.

—————R—————

The Work of Red Cross Organizations in Relation to the Preventive Medicine of the Future.

SIR ARTHUR NEWSHOLME, K.C.B., M.D.

(An address delivered at American Red Cross headquarters, Washington, D. C., May 2, 1919.)

It is difficult to give, as I am invited to do, in brief space and without the detailed reports of proceedings in which I took part, a clear conception of the conclusions reached at the extremely important International Conference of Red Cross Societies which was held in Cannes during April of this year.

I shall endeavor, however, to state the conception which gave rise to the conference and to give some of the conclusions reached by the experts in the number of departments of medicine on which are being based the initial steps for the organization of a new departure in Red Cross work.

It is unnecessary to remind actual Red Cross workers of the vast amount of beneficent work, rendered possible by the gifts of possibly half the American population, which has been carried out by your agencies in the various belligerent countries. The record of saving life, of alleviation of suffering, and in other instances of prevention of greater suffering, is one calling for gratitude and congratulation. This work has been rendered possible by an unrivalled combination of trained and of relatively untrained workers. The trained workers were indispensable; but without the invaluable assistance of intelligent, previously untrained, voluntary workers, a vast mass of suffering would have been left unalleviated and unrelieved.

This work in the main has been directed toward the healing of the sick and the wounded, but not entirely so; for most interesting and valuable work has been done among the civilian population of the belligerent countries, in providing medical assistance, in special work for the treatment of tuberculosis, in securing medical assistance and advice for mothers and their children, and in caring for those who have been rendered homeless by ruthless war. In America, also, Dr. Clark informs me that around military camps in states in which public health administration is imperfect, an organization has been evolved, through co-operation between the Central Public Health Service and the American Red Cross, by means of which territories about camps have been "cleaned up," the risks of malaria and other communicable diseases, including venereal diseases, have been minimized, a good milk supply assured, and elementary sanitation established. It is evident, therefore, that already the Red Cross, when local sanitary arrangements were imperfect or in abeyance, has taken upon itself the burden of the emergency preventive measures as well as of measures of relief.

In so doing it has acted wisely. Preventive work is always more productive in results than relief work. It is also more economical. It is wiser as well as more humane to erect a parapet along the top of a dangerous cliff than to provide an ambulance at its base.

I do not, however, wish to give countenance to the notion that prevention and treatment of disease must be regarded in antithesis. The two are parts of a whole and not distinct and separate. This may be illustrated by two of the most serious diseases to which humanity is subject, tuberculosis and syphilis. Of these, tuberculosis is probably the chief producer of dependent widows and orphans; while syphilis, on the authority of Sir William Osler, must be regarded as third among the killing diseases. For the prevention of both of these diseases treatment forms an indispensable preventive measure. Ev-

ery arrangement conducing to the comfort or recovery of the tuberculosis patient diminishes the risk of massive infection in his family; and the prompt treatment of syphilis by arseno-benzol preparations is the most effective means for securing his immediate disinfection as well as his progress toward cure. And even when the elementary personal infection is absent, it can be argued with justice that the prompt and efficient medical treatment and nursing of the sick not only diminishes the duration of individual disability, but prevents the impoverishment and enfeeblement of other members of the same family.

But for an increasing proportion of the total sickness of humanity, total prevention is now possible, and I need scarcely cite the almost complete disappearance of typhus in western nations in peace time, the rapid decline of enteric fever, and the improvement in regard to a large number of other diseases. The number of preventible diseases is being steadily increased, as investigation progresses, and as our knowledge of the already ascertained laws of health increases and becomes disseminated among the general population.

It was, therefore, a happy inspiration of Mr. Davison, the president of the American Red Cross, which led to his calling together the international conference of Red Cross societies at Cannes, with a view to considering means by which the worldwide activities of Red Cross workers might be utilized for the prevention of illness as well as for the treatment of sick and wounded mankind. It is a vision of the future, which I think will have a great influence on the welfare of mankind, if, as I am confident will be the case, the conception fires the souls of the multitude of Red Cross workers and contributors in every civilized country, and leads them to determine against demobilization of their forces, and to continue their beneficent activities against the horrors of peace, which, in the aggregate, are even more serious to mankind than those of war.

The statement that the devastations pro-

duced by disease in times of peace are even greater than the loss of life from war, may be illustrated by the experience of England and Wales. In the four years, 1911-14, immediately preceding the world war, 2,036,466 persons died in England and Wales, while, according to official figures, the total loss of men during the four and a fourth years of war was 835,743, including 161,800 presumed dead. The war figures give the entire loss for the British Empire; but it cannot be far from the truth to state that war on the gigantic scale of the war from which we have just emerged has killed in Great Britain about one-third as many as have died in the civilian population in a corresponding period. I do not lose sight of the fact that a large proportion of the civilian deaths occur in ripe old age, and that 28 per cent of the total civilian deaths occur among the children under 5, while those destroyed by war are adults and the most virile of our race. But the greater part of the deaths in childhood, as well as in adult life, before old age is reached, are preventible; and in the future will be prevented, given adequate research, intelligent and unsparing application of knowledge already in our possession, and an avoidance of the public parsimony which in relation to public health constitutes the most serious form of extravagance. That is the ideal which Mr. Davison and his collaborators place before us; and it was to devise plans to this end and to enlist the continued co-operation of all Red Cross workers that the conference was called at Cannes.

The conference held a number of general meetings in which the general policy to be pursued was discussed, and then divided itself into sections dealing with the following subjects: Preventive medicine, child welfare, tuberculosis, malaria, venereal diseases, nursing, information and statistics. These sections were not selected as covering the entire ground of preventive medicine, but as forming branches of work in which early investigation and action appeared to be most desirable.

But first of all the lines of general policy were discussed.

It is evident that although measures for the prevention of disease constitute a definite governmental function—neglect of which is treason to the communal welfare—even in the more advanced countries our governing bodies have not lived up to their potentialities. In scarcely a single sphere of its work can it be said of any government, or of any local authority, that what could be done to prevent disease and to avoid human suffering has been completely accomplished. To say this is merely to express the imperfections of humanity, singly, or the greater imperfections of committees and councils entrusted with the public purse and the public weal.

There is, and I think always will be, ample scope for supplementation of official work by voluntary workers, for the experimentation in new and promising work which it is so difficult to initiate in official circles, and for the undertaking of necessary work by devoted volunteers when public opinion and officialdom refuse to undertake it.

This disposes of the argument that Red Cross activities in the prevention of disease merely prevent the development of official work. The true object of all voluntary workers is to stimulate official public health work, and when in any sphere the latter is fully developed to welcome the disappearance or reduction of voluntary non-official work, or seek the new means of social help which are always waiting for devoted workers to initiate.

The conference agreed that the new work of the Red Cross would naturally divide itself into two parts: an international bureau, and national organizations. The duties of these and their relation to each other will be more clearly seen in the light of experience. The international bureau in the scheme proposed for the consideration of the conference—which received general approval—would act as a great center for collecting information on various public health subjects, and for digesting it and subsequently distributing

it by means of special publications, or periodical journals, or on application from those requiring specialized information. It would also act as a means of educating the general public on urgent problems affecting its welfare; and it would be utilized as a center, organizing in less favored communities, missions which would undertake local investigations and remedial work. These surveys and activities would be intended rather as demonstration centers than as permanent organizations, the intention being to withdraw them as soon as the necessary work could be carried on by local Red Cross or other organizations.

It was suggested that the central bureau should comprise a number of branches dealing with epidemic diseases, tuberculosis, venereal disease, child welfare, nursing and other subjects, collating and analyzing information and distributing it through the medium of the National Red Cross of each country.

Such a central bureau it will, I think, be agreed will be of the greatest value to all social and public health workers, while not clashing with any existent agency.

The proposed organization of Red Cross agencies for preventive work has already received an imprimatur in the draft league of peace; and it would be appropriate that its headquarters should be near if not side by side with the future home of that league. If it receives the full development for which we hope, it will form, perhaps, a chief instrument in securing peace and continued happiness for mankind.

The relation of the central bureau to National Red Cross societies will be one of mutual co-operation. The central bureau will provide information and facilities for national work; the actual work will need to be carried out in each country nationally and in the main from funds supplied by that country.

It is not intended that the National Red Cross shall undertake, much less compete with, work already being carried out either by local authorities or by existing voluntary associations. If, for instance, there is a society concerning itself with child wel-

fare, or the prevention of tuberculosis, or of venereal diseases, the National Red Cross would naturally give such assistance as it could through its voluntary workers in this special work, while leaving untouched existing arrangements. If no such societies existed, the National Red Cross might advantageously assist in their formation, retiring as soon as the separate organization was working.

In countries in which official and existent voluntary agencies scarcely exist, more active and continued direct work of the Red Cross organization will be called for; in such countries assistance may be needed from the central international bureau.

Evidently there are many points of central and national administration requiring and now receiving fuller and more detailed consideration; and all that need now be said is that it appears to me certain that international and national Red Cross organizations which will concern themselves with the prevention of disease as well as with the relief of suffering will be formed, and that they will have pregnant influence in hastening the reduction of human disease.

The second week's deliberations of the conference at Cannes were filled with meetings of committees of experts and more formal sectional meetings, at which lines of policy on certain specific subjects were formulated for the later deliberations of Red Cross societies in Geneva.

It is unnecessary to summarize in detail the scientific recommendations reached in various subjects. It may suffice, as indicating the wide scope of the field of work about to be surveyed, that among the more urgent problems of preventive medicine priority was given to advocacy of combined efforts for the prevention of the major pests of mankind, of the provision of laboratory assistance in the diagnosis of disease, and in securing more accurate vital statistics and improvements in public health legislation.

In child welfare work, the importance of health visiting, of child welfare centers, of an improved midwifery service, and of

continuous observation of children under school age as well as scholars was emphasized.

In regard to tuberculosis, stress was laid on the essential point that measures against this disease must embrace the whole of the sick lifetime of the patient, and must include, when necessary, measures for obviating the results arising from the fact that the partially recovered patient commonly is unable to earn an economic wage.

In the prevention of venereal diseases a similarly wide outlook was advocated, including the necessary social and moral as well as medical measures against their spread.

In the preceding brief statement I have endeavored to indicate the main outlines of the proposals considered by the Cannes conference. My statements are merely those of a participator in the conference; and it is evident that outside of the momentous decision to endeavor to retain mobilized the forces of Red Cross organizations and to secure their assistance in the great impending struggle against disease, no final decisions have been made. The growth of the central and of each national organization in the desired direction must necessarily occupy time, though I believe development will be rapid, once the great ideal is visualized clearly by Red Cross workers in each country.

I have referred in an earlier part of these remarks to the imperfections of governments, central and local, in the control of disease. These imperfections indicate one of the most promising fields in which voluntary agencies, like the Red Cross, can assist toward greater efficiency. Both local and central authorities are elected by the people themselves and the laws and regulations for the promotion of the public health—and what is even more important, the enforcement of existing regulations—depend for their efficiency on public opinion which we can all assist in forming. The natural tendency on the part of the social enthusiast who has been disappointed in his efforts at reform is either

to retire from the fight or to organize a voluntary organization having the same end in view. This last may sometimes be the best line to pursue, though in that case endeavor should be made to secure friendly relationship with, if not also the active co-operation of, the local authority. But often the most hopeful plan is to fight the local elections and to secure the election on local governing bodies of men and women who will give these bodies no peace until the necessary reforms are secured.

If we are to be helpful we must be kindly and charitable in our criticism of local authorities. Nothing has made it so difficult to secure good men and women to undertake the burden of local government as the indiscriminating and uncharitable criticism aimed at those engaged in it. Criticism of members of our central and local governing bodies is not seldom deserved; but critics are too often those who will give no assistance in the work which, with insufficient knowledge, they vilify. When we hear of scandals in administration, let us have a sense of proportion, remembering the grosser corruption evidenced for instance in Pepys' Diary and especially remembering that the best way to remove corruption is by ourselves taking a part in the work of central or local government, or by steadily upholding those who are doing so with integrity.

The onlooker, whether it be on voluntary or on official work for the commercial good, has his duty to perform as well as the worker. It is his duty to make himself acquainted with local conditions and with local administration, even though he takes no part in it. A chief need at the present time is an interested study by every adult of all the phases of local administration in each district; and in my view Red Cross organizations will be rendering inestimable service to the community if they succeed in educating the public conscience to this effect. Increased local patriotism is urgently needed if the prospective fight against disease by the Red Cross societies is to succeed, and if the further triumphs of preventive medi-

cine within our reach are to be secured. To this end enthusiasm will need to be infused into official public health administration as well as into the work of voluntary agencies; and it is only by developing all the possibilities of our governing bodies as well as of voluntary societies and by securing the closest co-operation between the two that the new ideal of the Red Cross organization can be realized.

—R—

Dressing for Burns

Torald Sollman reports that solutions of dichloramine-T in chlorcosane do not protect the large open surfaces of burns against mechanical irritation and access of air. On the contrary, the solution is absorbed by the dressing, which is then glued by the wound secretions and causes pain and injury when the dressing is changed. As a result of a study of the decomposition of dichloramine-T by different solvents, Sollman proposes the use of an ointment of three parts of surgical paraffin and seven parts of liquid petrolatum as a protective dressing on wounds (burns) treated with dichloramine-T-chlorcosane solution. It may even be used as a basis for a dichloramine-T ointment.—Journal A. M. A., April 5, 1919, p. 992.

—R—

Dakin's Solution

According to New and Nonofficial Remedies, 1919, surgical solution of chlorinated soda may be prepared: 1. By the electrolysis of a sodium chlorid solution. 2. By the action of chlorin on sodium carbonate. 3. By the interaction of chlorinated lime and sodium carbonate solutions with subsequent treatment with either boric acid or sodium bicarbonate to reduce the alkalinity.—Journal A. M. A., April 5, 1919, p. 1021.

—R—

There is no evidence of latent injury to the dental nerves from repeated injections of procain to control supersensitiveness of the teeth. If an isotonic solution is used and this solution made sterile by boiling, it is not probable that it will be injurious.—Journal A. M. A., April 8, 1919, p. 1022.

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The Annual Meeting

Most of us were a little pessimistic about the meeting at Ottawa—before the meeting. Few of us expected to see more than a hundred—or possibly a hundred and fifty—in attendance. We had been assured by traveling men, who were visiting the doctors in various parts of the state, that very few of them expected to attend. It was generally admitted that Ottawa, without the facilities of its new hotel, would be unable to accommodate the usual number of visiting members. It was also a matter of general comment that the physicians in Kansas had lost interest in the Society during the war, and that the increased amount of sickness would prevent many of the faithful from being present at this meeting.

The meeting itself proved us all bad guessers. There were two hundred and thirty members registered, and there were at least twenty in attendance who did not register. In view of the fact that there are at least two hundred of our active members still in service that is a very good attendance. Among those present were many of the busiest practitioners in the state. In spite of the unexpected large attendance, the Ottawa physicians were

able to find accommodations for all of them.

The Franklin County Society has not a very large membership, but it does seem to have a large proportion of live ones. It was rather discouraging when it was found that the new hotel would not be ready for occupancy, but the citizens were called upon to open their homes to the visiting physicians and every one had a good bed to sleep in and found plenty of good food. Neither were they to be outdone by the larger societies in the state in the matter of entertainment, for on Wednesday evening an excellent banquet was spread in the dining room of the Nelson and with sweet music and good cheer we were made to appreciate in full the hospitality of Ottawa and the medical fraternity of Franklin County.

One of the very striking and pleasing features of this meeting was the unusually small number of vacancies on the program. At no previous meeting in our recollection have so many of the men on the program been on hand to respond when their names were called. At no previous meeting in our recollection has the attention of the members been so completely given to the program.

The lectures by Dr. Bowman on "Hospital Standardization," by Dr. Ochsner on "The Treatment of Flat Foot," by Dr. Kanavel on "Experiences in Spinal Cord Surgery," and by Dr. Binnie on "The Handling of Patients at the Front" were in themselves sufficient to compensate any of us for the trip to Ottawa. But the program as a whole was an unusually interesting one.

The first meeting of the House of Delegates was held at 4 o'clock on Wednesday. At this meeting the reports of the various officers and the members of the Council were presented. At this meeting the proposed amendments to the constitution and by-laws were submitted, as printed in the Journal, March and April numbers. These amendments were unanimously adopted without alteration. The House of Delegates met again, at 9 o'clock on Thursday,



W. S. LINDSAY, M.D., TOPEKA
Retiring President Kansas Medical Society





ELMER E. LIGGETT, M.D., OSWEGO
President-Elect, Kansas Medical Society

for the election of officers. As usual a great deal of time was unnecessarily wasted in the absurd custom of making nominations for part of the offices by secret ballot. There are always three vice-presidents to be elected. There are no candidates for vice-president. No one has ever made a choice of men for these offices and invariably the ballot results in a very large number of nominees from whom eliminations must be made by further balloting before the final ballot for election can be taken. Almost invariably, after much time has been consumed in this way, the election is finally made by acclamation, and after the vice-presidents are elected the remaining officers are elected by instructing the Secretary to cast the ballot of the House for someone for each particular office. It is certainly a most irregular and irrational procedure, but every one is apparently satisfied with the results, and that is after all the most important thing.

Dr. E. E. Liggett, of Oswego, who was elected president, has long been an active member of the Society, has taken great interest in its affairs and has done much toward building it up to its present standing. We predict a prosperous year for the Society under his administration.

According to the schedule six councilors should have been elected at this meeting, but the House voted that the councilors from the ninth and eleventh districts should not be elected at this time, so that next year and each succeeding year there will be four councilors to elect. The councilors from the third, sixth and tenth districts were re-elected. Dr. W. F. Fee, of Meade, was elected councilor for the twelfth district. Prior to the fiftieth annual meeting Dr. Fee had served several terms as councilor from the twelfth district with credit to himself and honor to the Society.

The House was informed that the Society was now entitled to three delegates to the American Medical Association. The retiring president, Dr. W. S. Lindsay, and Dr. R. J. Morton were elected to represent the Society for the next two years.

The Control of Venereal Diseases

The following resolutions were adopted by the members of the Kansas Medical Society in session at Ottawa, May 7 and 8:

"Whereas, the Kansas State Board of Health in co-operation with the United States Public Health Service is conducting a vigorous campaign against venereal diseases, and

"Whereas, physicians are particularly interested in that part of the campaign which relates to the diagnosis and treatment of venereal diseases, and

"Whereas, the Kansas State Board of Health has arranged to provide facilities for free laboratory examinations of specimens for the diagnosis of venereal diseases, to furnish free arsphenamine for indigent cases and has adopted the policy of establishing clinics for the treatment of venereal diseases in the larger cities.

"Therefore be it resolved that the Kansas State Medical Society heartily endorses the campaign being waged by the State Board of Health and especially that part of the campaign which provides facilities for the diagnosis and treatment of venereal diseases, and

"Be it further resolved, that the Kansas State Medical Society call upon all physicians in the state to co-operate with the health authorities in their efforts to combat venereal diseases, and

"Be it further resolved, that the local authorities in the larger cities of the state be urged to provide for the establishment of clinics in co-operation with the State Board of Health, and

"Be it further resolved, that copies of these resolutions be sent to the Surgeon General of the Public Health Service, the Secretary of the State Board of Health, the editor of The Journal of the American Medical Association, and the editor of the State Medical Journal, with a request that they be published."

—R—

Physical Training in Public Schools

The following resolution was introduced at the recent meeting of the Kansas Medical Society by Dr. W. F. Sawhill and was unanimously adopted by that body:

"Resolved by the Kansas Medical Society in fifty-third annual convention assembled that it favors the making of thorough physical training in all the public schools of the state a part of the course of instruction, thus better fitting the pupils not only for the duties of civil life but

making them better able to serve their country promptly in case of any future national emergency."

—————R—————

The Council, at its meeting on Wednesday, authorized the appointment of a committee to procure the portraits and historical sketches of the organizers of the Kansas Medical Society and its numerous ex-presidents and such historical data in regard to the Society as may be of special interest, and place all this in the custody of the State Historical Society.

—————R—————

The editor has been instructed by the Council to prepare the amended constitution and by-laws for publication, and to have them printed in convenient form, together with the compiled resolutions that have been adopted from time to time for the government of the Society. They will be published in a pocket edition and a copy will be mailed to each member of the Society.

—————R—————

We are having much trouble in keeping in touch with members who have been discharged from the army service. It will help us materially if secretaries of county societies will report to the Journal office the names of their members who have returned home and also those who have changed locations.

—————R—————

Excerpts—By The Prodigal

"DON'T BE SOT."

"He be sot in his ways." It is almost impossible for a man to free himself suddenly of preconceived notions or opinions. It is a gradual process and takes time to ease down. It takes time to readjust or reverse the intellectual machinery the same as it does in a speeding automobile. In going at a high rate of speed or intellectual pressure a sudden stop or reversal of the machinery is liable to injure the speeder or damage the machinery—except a Ford!

An open mind to suggestion is a progressive and safe mind, providing that the

primary and emergency brakes of the intellectual machinery are in good condition. There are many makes of automobiles but none of them are mechanically perfect. Not one of them satisfies the ideals of the mechanic. But if he is a good mechanic he will be open to suggestion and able to see the defects when pointed out to him and improve on the original machine and line up with the age of mechanics. On the other hand if he has a nut for a head there is no future for him. It is the same way with a doctor. He must keep his mind in an elastic, receptive mood toward new things and discoveries in everything, to keep young and not moss over. If he does not do so he is soon classed with and treated as a deficit—and red-inked.

The infinite varieties of human beings and their diversity of interests are liable to throw the doctor off his balance in the treatment of his patients and to permit himself to follow the line of least resistance or a course of indifference in his practice. He is liable to be confused, for he can see no unison or harmony in these discordant and contradictory manifestations in these subjects he is called upon to treat. To the supersensitive doctor this bedlam is liable also to make him daffy or want to quit. The careless, slacker doctor is but slightly if at all perturbed and his indifference proves an anodyne to him.

The two dispositions or cuts of mentality are aptly illustrated by the explanation of the negro as to why a greater percentage of white men committed suicide than negroes. "Well, I tells yo', Boss,—when a white man has troubles and things go wrong, he goes off and sets down to think he troubles ober and he gits all tangle up and de more he thinks, de wus he gits, and he goes off an' kill hissef. Now a nigger he has troubles and git all fussed up and he goes off and sets down to 'sider matters and he jis' natur'ly goes to sleep." There is meat in both cocoanuts. The happy medium is a combination of the two mentalities. And he is the happy successful doctor who can get the mixture

or compound so exact that there will be no precipitate.

Moral—Be neither finicky nor *sot*.

EMPIRICISM

There were three principal schools of medicine among the ancient Greek physicians. Those who founded their practice on experience called themselves empirics; those who relied on theory, methodists; and those who held a middle course, dogmatists. An empiric was one who relied on practical experience alone. He is one who disregards the rules of science and regular practice. The methodists rejected observation, and founded their practice on reason and theory. The dogmatist based his practice on assumption—on “Thus saith the Lord.”

Up-to-date medicine eschews these athies, paties and isms and classification of the ancient—the single track idea and practice, and combines into one, practice, observation, experience and reason and is chary of dogmatism. The dangerous doctor then as now was and is the cocksure, skin-of-the-toad-will-cure-the-wart dogmatist. The practice of medicine is more sensible, has a better scientific foundation than ever before in its history. But it must not be forgotten that science owes its origin to the empiric.

Empirical or personal observations and experiences have been raised to a science by statistics; and thus science was born. And whatever of science there is in medicine and surgery is due to classified, systematized empiricism.

Moral—In addition to what empiricism and science has done for medicine and surgery, we must classify and systematize our own observation and experience to be dynamic and not static physicians.

The contract has been let for an Onco-logic Radium hospital to be built in Los Angeles, at a cost of \$200,000.

Moike—“Whin yez sees wan Ford keer goin’ down the sthrait afther another wan, phwat time o’ day is it?”

Pat—“Tin afther tin, ye bloke!”

THE HEBREW OF IT

Jew in Los Angeles—“I vant a dicket to Portland.”

Ticket Agent—“Portland, Oregon, or Portland, Maine?”

Jew—“Vitch is de sheepest?”

A young man of large stature but short on erudition called on a lady acquaintance of whom he was enamored, and looking at her with loving eyes and beaming countenance, complimented her to the best of his ability by saying, “You look fine! You look just like a morfedite!”

The above is a sure, true, cross-my-heart story on a young Kansan.

An old colored woman in Topeka said that the doctor had cut out her boy’s asteroids.

“Queen Victoria of Spain was operated on successfully for hysteriasis.”—Press Dispatch.

Teacher—“What is a dogmatist?”

Pupils (in unison) — “One who sells dogs.”

NEW USE FOR A FAT MAN

The fulmar, a sea bird common on the Island of St. Gilda, is so oily that when the natives kill one they simply pass a wick through its body and use it as a lamp.

“Where science ends, faith begins.”

Science teaches us to know and art to do.

Science is systematized knowledge.

Empirical, what belongs to experience or observation.

Empirical observation can be raised to scientific truth.

—————R—————

DEATHS

Samuel Alton Johnson, M.D., aged 60 years, died at his home in Topeka, May 25, from an illness beginning in an attack of influenza.

Dr. Johnson was born in Clarksburg, Ohio, May 3, 1859. He graduated from

the Kansas Medical College in 1897, was for several years demonstrator of anatomy and later professor of electro-therapeutics in that institution.

He had been in the general practice of medicine in Topeka for the past twenty-two years. He was a member of the Kansas Medical Society and was an ex-president of the Shawnee County Medical Society.

Robert Arthur Gilliford, M.D., aged 49, died at the home of his brother in Olsburg, Kansas, March 13, from cerebral hemorrhage.

Dr. Gilliford graduated from the Kansas Medical College in 1899 and subsequently practiced for several years in Pennsylvania, but on account of ill health retired from practice and has lived in Kansas since that time.

JAMES PARKER BLUNK, M.D.

The medical profession lost a distinguished member, and the community of Ottawa one of its most esteemed citizens, in the recent death of James Parker Blunk, M.D., after ten days illness from influenza and pneumonia. He died at his home in Ottawa on the morning of March 17 at the age of 44 years. Dr. Blunk was born in Berry County, Missouri, received his early education in the public schools of his native county and later attended college at Springfield, Mo., and the Missouri State University. With the completion of his academic education he entered Ensworth Medical School at St. Joseph, Mo., from which institution he received his medical degree after four years of study. After his graduation he engaged in general practice in Atchison, Kansas. He did not find this agreeable to his taste and ambition and at the end of two years he entered the office of Dr. Barton Pitts, a specialist in the eye, ear, nose and throat. He remained with Dr. Pitts three years and then went abroad to further pursue his studies along these special lines. He spent some time in Heidelberg and later went to Freiberg, where he devoted three years to

special study under the direction of masters in his chosen field of labor.

Returning to the United States he sought at once a location. He went to Wichita, Kan., and found the field pre-occupied by a number of skilled and competent men in his line of work. He then sought the advice of Henry J. Allen, now Governor of Kansas, and Mr. Allen wisely advised him to locate in Ottawa. This he did, and his success here was phenomenal. He quickly acquired an enviable reputation in his special field of labor. He commanded a large clientele throughout eastern Kansas and in all the territory adjacent to Franklin County. He was a skillful operator, a wise counsellor, and conscientious in all that he did and said. His fellow members in the profession more than esteemed him; they loved him. The general public had a warm-hearted devotion to him—men, women and children alike.

Dr. Blunk was an ardent devotee at the shrine of everything that was uplifting and ennobling. In the civic life of the community he was always active, and no good cause failed to receive his endorsement and support. He had a warm, genial, sympathetic nature—a personality that even in the absence of special qualifications would almost insure a man success. At the age of 28 he married Miss Cora Judah of De Kalb, Mo. Four children were born to this union, all of whom with the mother survive and now live in the beautiful home erected by the lamented doctor, devoted husband and considerate father. Dr. Blunk was a member of the Franklin County Medical Society, the Kansas Medical Society, and a Fellow of the American Medical Association.—FRANKLIN COUNTY MEDICAL SOCIETY.

BOOKS

Quarterly Medical Clinics—Vol. I, No. 1

A series of consecutive clinical demonstrations and lectures by Frank Smithies, M.D., at Augustana Hospital, Chicago. Published quarterly by Medicine and Surgery Publishing Co., Inc., Metropolitan Building, St. Louis, Mo. Price per number, paper, \$1.50.

The first number of the Quarterly Med-

ical Clinics is fully up to the specifications made in the announcement which appeared in the Journal some months ago. The series of clinics presented in the first number are interesting and instructive. The cases are carefully and systematically analyzed and the points upon which the diagnoses are made are fully set forth. The makeup of the book is all that could be asked and the illustrations are numerous and appropriate.

Vaccine Therapy in General Practice

By G. H. Sherman, M.D., with quotations from other authors. Third edition. Published by G. H. Sherman, M.D., Detroit, Mich.

In the first part of this book the author reviews the underlying principles of vaccine therapy, discussing first the anti-bacterial substances of the blood, then the opsonins, germ and tissue ferments, the digestive ferments produced by the germs, and finally immunity and the various methods by which immunity is produced. The remainder of the book is devoted to the discussion of the application of vaccine therapy, in which the author presents his own observations as well as those of other observers as to the effects of vaccine therapy in various disease conditions.

New and Nonofficial Remedies—1919

Containing descriptions of articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1919. Published by the American Medical Association, 535 North Dearborn Street, Chicago, Ill.

It should be borne in mind that as a rule articles which are included in the U. S. Pharmacopeia are not described in New and Nonofficial Remedies. It is the purpose of the Council to pass upon those remedies that are not classed as official but which are constantly being promoted by the manufacturer for therapeutic use. Only such preparations as meet certain rules of the Council are accepted. It should also be borne in mind that the admission of an article to New and Nonofficial Remedies does not imply a recommendation by the Council, but simply means that its rules have been complied with. Many preparations which were in-

cluded in the last edition have been excluded from this one.

Ultra Violet Rays in Modern Dermatology

Including the evolution of artificial light rays and therapeutic technique by Ralph Bernstein, M.D., Philadelphia. Published by Achey & Gorrecht, Lancaster, Pa.

This is a little volume of 160 pages devoted entirely to the use of light rays in the treatment of skin diseases. The author's conclusions as to the value of this form of therapy are based largely upon his own experience. Considerable space is given to descriptions of the apparatus used and the technique employed.

SOCIETY NOTES

KINGMAN COUNTY SOCIETY

The Kingman County Medical Society met in regular session on Thursday evening, April 17, at Kingman. Major W. A. Phares, Wichita, gave a very interesting lecture on his war experiences in France. After the lecture a banquet and smoker was freely enjoyed by all present.

There were present from outside of the county Drs. W. P. Callahan, J. W. Cheny and W. A. Phares, of Wichita; Drs. C. E. Phillips and Campbell, of Pratt, and Dr. Buhler of Pretty Prairie.

B. H. POPE, Secretary.

CHEROKEE COUNTY MEDICAL SOCIETY.

The Cherokee County Medical Society met in Columbus April 16, 1919, with Dr. F. L. McKinney, president, in the chair. Members present: Drs. Loudermilk, Shelley and McKinney of Galena, McCormick, Cannon and Wear from Baxter, Reed of Mineral, Markham of Scammon, and Johnson, Griswold, Brookhart and Graham of Columbus.

Present also were Messrs. Share and Rambo, Cherokee County sanitary inspectors, and Miss Shockley, who is doing a tuberculosis survey of Cherokee County for the State Tuberculosis Society.

Dr. Elmer Liggett of Oswego, a member of the Labette County Society, was the principal speaker of the evening. He

gave a splendid talk on surgical tuberculosis.

The society will meet twice a month, next meeting will be at Galena April 30.

J. DALE GRAHAM, Secretary.

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The Vaccine Treatment of Diabetes

Diabetes has been considered an obscure functional disease for such a long time that it is somewhat difficult to associate it with an infection and, consequently, amenable to vaccine therapy.

From a closer study of sugar metabolism it has been demonstrated that this function is maintained by internal secreting organs, which secrete a substance that has the property of converting sugar into glycogen so it can be stored and utilized as required; and that this function is largely, if not entirely, performed by the pancreas, more particularly the islands of Langerhans in the head of the pancreas, and that in diabetes these secretory organs are disturbed or destroyed.

That inflammation of the pancreas is very closely associated with diabetes is now quite generally recognized. Max Einhorn (*Journal A. M. A.*, July 10, 1915, p. 149) points out in a critical analysis on pancreatitis that Opie contends that the islands of Langerhans are diseased in 85 per cent of diabetes cases and that generally a diagnosis of chronic pancreatitis can be made out.

Modern pathology, through the study of bacteriology and infection, has led us to a point where we can hardly conceive of an inflamed organ without ascribing the condition to an infection. That a chronic infection by the common infecting organisms may develop in the pancreas as well as in the liver or other organs can not be doubted. If the contention that the islands of Langerhans are internal secreting organs, and that they secrete a substance which controls sugar metabolism is correct, we can readily understand how an infection can disturb or even destroy their function with a resulting diabetes. From this viewpoint vaccines are most logical remedies to use in the treatment

of diabetes, and the results so far obtained justify this position.

Dr. G. H. Sherman, of Detroit, Michigan, has done considerable original work on the subject of diabetes and has arrived at new and interesting conclusions.

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Dobell's Solution

Somebody (God forgive him!) recommended spraying of the nose and throat with Dobell's solution as a prophylactic for Spanish influenza. Apparently every newspaper in the United States has printed this suggestion.

Dobell's solution is of such slight value as an antiseptic that we feel it our duty to warn the profession against putting their faith in it. As every doctor knows, this is a weak alkaline solution, containing borax and bicarbonate of soda, in a little glycerin and much water, rendered feebly antiseptic by the addition of three parts per 1,000 of phenol; in other words it contains one-third of one per cent of carbolic acid. The only value a solution of this kind could have would be for the removal of mucous secretions from the nose. For this purpose it might have some slight merit.

As an antiseptic, however, Dobell's solution is a joke. Such a solution is not equal in antiseptic power to one made by dissolving one Chlorazene tablet in five quarts of water.

When people are using antiseptic solutions to prevent a terrible disease like Spanish influenza, they want something which is really of value. It is criminal to advise them to put their faith in a preparation like this, when really powerful germicides like Chlorazene can be obtained at almost any drug store.

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Federal Trade Commission Dismisses Complaint

At a regular session of the United States Federal Trade Commission held in Washington, D. C., March 10, 1919, the complaint against the Victor Electric Corporation was ordered dismissed and discontinued. We congratulate the officers

and members of the Victor organization on this vindication.

The personnel of the Victor organization is largely made up of pioneer workers in the X-ray and physical therapy field and we have always believed that these men (who are directing the policies of the Victor Electric Corporation) have been actuated by a desire to elevate rather than to lower the standard of business ethics in their* field.

The Victor Corporation is to be congratulated upon having had this opportunity of having the Government searchlight turned upon its activities, and the clean bill of health which the corporation has received should be an inspiration to its officers to continue to be guided by those ideals which should be kept in constant view by all who are engaged in an industry so closely allied to medical science.

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The Red Cross in the Balkans

Nineteen American women doctors are now in the Balkans, assisting the American Red Cross in its work of caring for the sick and destitute. These doctors are from the American Women's Hospital at New York and are located in Serbia, Montenegro and Albania. Already their work has earned the warmest commendation of the government. Some of them have received decorations or been cited for conspicuous service among the soldiers and refugees.

In Serbia, where the most sickness and destitution exist, the following women physicians are at work: Dr. Marjorie Burnham of Ashtabula, Ohio; Dr. Mary H. Elliot of New York; Dr. Harriet M. Gervais of Dorchester, Mass.; Dr. Alberta M. Greene of Judith Bay, Mont.; Dr. Lulu Peters of New York; Dr. Marion C. Stevens of Reading, Mass.; Dr. Regina Flood Keyes of Buffalo, N. Y.; Dr. Mabel Flood of Elmira, N. Y.

Dr. Catherine M. Cook of Washington, Pa., and Dr. Dora E. Bowman of Kansas City, Mo., are assisting the American Red Cross doctors in Montenegro. Dr. Nell G. W. Bartram of Huntingdon, Pa.; Dr.

Mary J. Hyndman of Philadelphia, and Dr. Sarah E. Foulks of Burlington, N. J., are doing similar work in Albania.

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Annual Meeting of the Council on Pharmacy and Chemistry

Among the subjects considered at the recent meeting were: The Council decided to publish at an early date a report on the unscientific and commercial propaganda for nonspecific protein therapy. The Council appointed a committee to study the problems of serum and vaccine therapy with a view of publishing the evidence obtainable regarding both the values of, and also the dangers incident to, the use of serums and vaccines. A special committee was appointed to report on the present status of pollen extracts in the prophylaxis and treatment of hay fever. The Council adopted a resolution urging legislation which shall require the Public Health Service to extend its control of serums, vaccines, toxins and antitoxins to cover other potent remedies that are used hypodermically or intravenously. The Council passed a resolution that the control of arsphenamine by the Public Health Service shall be continued and the price controlled by the government. The Council decided to describe in a separate section of New and Nonofficial Remedies proprietary preparations of therapeutic value which are so exploited as to be inadmissible to New and Nonofficial Remedies. A committee was appointed to establish fuller co-operation between teachers of therapeutics and pharmacology in medical schools and the Council. A committee was appointed to determine the present status of radium water therapy.

—Journal A. M. A., April 26, 1919, p. 1243.

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Germany and the American Chemical Industry

The Alien Property Custodian has issued a report which, in part, is devoted to a discussion of the influence which Germany has had on the chemical industry in the United States. It outlines how the German government obtained a practical

monopoly in the United States in dyes, fine chemicals and synthetic drugs. The report explains how by-products of the dye works were converted into explosives—trinitrotoluene, for instance—and the advantage which the production of these explosives gave to Germany as a military power. The report explains that in medicinal chemicals very little real manufacture existed in the United States. The report discusses the ramifications of the "Big Six"—the German concerns which controlled the dye industry—in American industrial life and describes how their American branches were shown to be enemy-owned and therefore taken over by the custodian. The "Big Six" were: Badische Anilin and Soda Fabrik, Farbenfabriken vorm. Friedr. Bayer & Co., Actien-Gesellschaft fur Anilin-Fabrikation, Farbwerke vorm. Meister Lucius & Bruning, Leopold Cassella, G.m.b.H., and Kalle & Co. Aktien-Gesellschaft. The American firms were: Badische Co. of New York, Bauer Chemical Co., Bayer & Co. (Inc.), Berlin Aniline Works, Casella Co., Farbwerke Hoechst Co., Heyden Chemical Works, Kalle & Co., Merke & Co., Roessler & Hasslacher Chemical Co. and Synthetic Patents Co. (Inc.) The report closes with a description of a corporation to be known as the Chemical Foundation, Inc., which is to acquire by purchase the German patents which in the past have formed a colossal obstacle to the American dye-stuff industry. The Alien Property Custodian has sold to this company for the sum of \$250,000 approximately 4,500 patents.—*Journal A. M. A.*, April 19, 1919, p. 1176.

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Endamabiasis.

S. K. Simon, New Orleans (*Journal A. M. A.*, Dec. 21, 1918), says that ipecac had fallen into almost complete disuse at the end of the last century, probably owing to its occasional disagreeable effects. It is still found effective in warm climates and has maintained the foremost place in combating the dysenteries there prevalent. He gives other items of the history of the re-

vival of its use, and reports his own experience with a pill made of the powdered root. The use of emetin has been substituted, but evidences of its inferiority to the crude drug in the treatment of dysentery has accumulated. The protozoan of the disease, when encysted, has acquired a special resistance to the drug and relatively small amounts of emetin, while relieving the clinical symptoms, may drive the organism into encystment, and thus have the opposite effect from what was intended. Certain ill effects of emetin on the system have been observed, and perhaps the most notable article showing this is that of Pellini and Wallace, in which they formulated the following conclusions: "1. Emetin depresses, and may eventually paralyze the heart. 2. It is a powerful gastro-intestinal irritant, whether given by mouth or by subcutaneous injection. 3. It causes a definite derangement of metabolism characterized by an increase in nitrogen loss and an acidosis. 4. While in normal individuals, given moderate doses, these actions may not be of importance, in pathologic states of the circulation, intestinal tract, or metabolism, there may be a very definite source of danger." Two other alkaloids have been derived from the ipecac root, namely, cephaelin and psychotrin, the former of which is very similar in its effects, but more powerful than emetin, and therefore equally or more objectionable. Massive doses, therefore, cannot be tolerated, while with the use of the ipecac mass orally, in daily amounts as high as 75 grains, yielding approximately 1.5 grains of alkaloids, a concentration of the effective properties of the drug is obtained in the infected colon without any possible danger of toxemia. In the treatment, first of all, it is essential that the patient be put to bed for its full course, ordinarily only ten days, and the diet restricted to food that leaves no residue in the intestinal tract. A dose of castor oil should be administered in the morning of the first day, and in the evening about 9 o'clock, from ten to fifteen salol-coated 5-grain pills of the powdered ipecac should

be given, no food being given for two hours before, and for six hours after their administration. The complete dosage includes the retention of at least 100 pills, and if there is trouble from nausea or vomiting an extra enteric coating should be added to the pills. Under ordinary circumstances, however, Simon has found a coating of one-tenth inch sufficient. This crude ipecac treatment, Simon asserts, kills the ameba, giving it no chance to encyst itself (which the alkaloids, in safe doses, do) and kills the encysted forms also.

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Surgery of Arteries.

F. C. Herrick (Cleveland), Camp Crane, Allentown, Pa. (Journal A. M. A., Dec. 28, 1918), as results in his studies shows the disadvantages of introducing foreign bodies in the surgery of large arteries and aneurysms. Protocols of his experiments are given and a fuller report is promised for later publication. The summary and conclusions as to the work so far carried out is thus given: "1. Strips of rectus fascia with muscle attached of varying size up to three-fourths that of the aorta of dogs may be placed through a dog's aorta or carotid without causing permanent clot or thrombosis. In certain cases no clot at all is formed. 2. In over half the experiments, the contraction of the aortic walls about the inserts and of the inserts against the slits in the aorta entirely controlled hemorrhage. In the remaining cases, from one to four simple sutures controlled bleeding from the corners. 3. These inserts diminished the lumens of the aortas to approximately one-third to three-fourths their former volume. 4. Such inserts may be used to diminish the volume of a large artery, to diminish the orifice of a sacculated aneurysm, to favor thrombosis of the aneurysmal sac by being placed through it, or to limit the size of a fusiform aneurysm by being placed so as to exclude certain sectors from the current. 5. In no cases have symptoms of embolism been noted. The only pathologic observations to exclude such occurrence were: (a) In two

cases examined at necropsy within six days, no clot was formed at all. (b) In four cases examined at necropsy later than six days, no clot was present. (c) In all cases but one, when a clot was formed it took a uniform, blunt tipped icicle shape, was quite firm, and would not easily break off. 6. A patch of fascia or muscle may be sutured to an arterial defect with perfect functional results. 7. The sac of an aneurysm or the vessel proximal to it may be lessened in volume by such inserts. 8. An arterial patch of muscle and fascia in a dog is consistent with perfect function of the artery."

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Pollakiuria.

Pollakiuria, or increased frequency of micturition, has been studied by W. W. Kahn, Detroit (Journal A. M. A., Dec. 7, 1918), who in a former paper reported sixty-four cases under the false title of polyuria. He calls attention to the looseness of the terminology of urinary disorders in medical literature, and gives a classification of these conditions. Pollakiuria does not mean excessive urination, but only its increased frequency, as he defines it. He quotes from several authorities as to the frequency and causes of the condition, mainly remarks made in the discussion of Dr. Bugbee's paper, published in The Journal of March 3, 1917, in which he had ascribed the increased frequency of urination in women to some neurosis or other. He also quotes from Michael Foster's Physiology, in which he intimates that the tone of the bladder is regulated by the nervous system. The truth of this was brought home to Kahn by a case which he reports, in which the symptom was relieved by treatment directed to the condition of the eyes—relief of eyestrain. He also mentions another case similar in that the treatment of refraction trouble was attended by less frequent micturition. This caused him to look up the literature on the subject, which he found almost nil. He therefore began to make a systematic inquiry of all his refraction patients, and found that about 20 per cent of 1,500 new

cases (140 men and 176 women) had pollakiuria. Of 316 patients, especially questioned as to the effects or refraction on this symptom, 126 returned to report. Of these 126 cases, eighty-five reported great improvement or recovery from correction of their refraction trouble, the percentage in women being twice as large as that in men. The figures are not conclusive, the number being too small, but certain facts stand out preeminently: first, that the percentage of recoveries in women is nearly twice as great as that in men, and is probably due to their greater nervous instability; and second, the frequency of pollakiuria as a neurosis is very much greater than has been supposed. Other factors, besides eyestrain, may influence it possibly to a lesser extent. Kahn concludes as follows: "1. Pollakiuria, or excessive frequency of micturition, must be strictly differentiated from polyuria and incontinence of urine. 2. In a great percentage of cases, pollakiuria is a neurosis, brought on by malfunction of a distant organ, especially the eye. 3. Contrary to the general medical opinion, pollakiuria is nearly as frequent in men as in women. 4. Before a surgical interference is tried, a careful refraction should be indicated in all cases of pollakiuria, except those in which it would have to be done for reasons other than the excessive frequency of urination."

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Lethargic Encephalitis.

F. A. Ely, Des Moines, Iowa (Journal A. M. A., April 5, 1919), reports two cases of lethargic encephalitis, one of which has undergone thorough laboratory investigation. In his comments on these he remarks that there was no history of previous influenza in either of these cases, unless the mild febrile disturbance which ushered in the illness might be regarded as such. He also notices the bodily lethargy in these cases as similar to that in Parkinson's disease, and says it is only fair to assume that minute hemorrhagic areas in the corpus striatum observed in lethargic encephalitis may produce the same symp-

toms as the degenerative area in the same structures in Parkinson's disease. Another point of interest is the fact that when lumbar puncture was made in the second case and 20 c.c. of spinal fluid was removed, the patient at least partially woke up, volunteered statements and asked about some of her possessions which she had put away for safety. This was after five days of absolute silence and apparent indifference, during which time she answered only questions given in an imperative manner.

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Anthelmintics

The earthworm reacts with symptoms of toxicity to all clinical anthelmintics just as do the parasitic intestinal worms. This fact has enabled Torald Sollman to re-investigate the claims long made for certain drugs. *Spigelia* was found to have rather feeble toxicity, but fresh pumpkin seed and squash seed were quite highly efficient.—Journal A. M. A., April 26, 1919.

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The doctor should always have an hemostatic in his case. There is liable to be need for it any minute. Thromboplastin Solution (Armour) is a specific hemostatic and acts promptly. Thromboplastin (Armour) is made from the fresh brain of kosher killed cattle. There is a certain amount of that blood clotting thing in an animal's brain and this is not used up when the animal's throat is cut. It is used up when an animal is killed with a hammer. In the Armour laboratory kosher killed cattle brain is used in making Thromboplastin. That's why Thromboplastin Solution (Armour) works promptly.

—————R—————

The Physicians' and Surgeons' Adjusting Association, of Kansas City, Mo., wishes to call the attention of physicians in this field to the fact that they collect old accounts. This Journal has accepted their advertisement, which will be found on another page of this issue, and any business transacted with this company will no doubt be entirely satisfactory to those who have dealings with them.

A Daily Demand exists for



Pituitary Liquid (Armour)

a physiologically standardized solution of Posterior Pituitary Substance that is entirely free from chemical preservatives.

$\frac{1}{2}$ c.c. ampoules for obstetrical use
1 c.c. ampoules for surgical use (boxes of 6)

Corpus Luteum (Armour)

is made from *true* substance and is indicated in the disturbances incidental to the natural and artificial menopause and other gynecological cases; powder, 2 and 5 grain capsules and 2 grain tablets.

Thyroids and Thyroid Tablets (Armour)

run uniformly in iodine content. Thyroids is indicated in a large number of diseases. We offer Thyroid powder, and $\frac{1}{4}$, $\frac{1}{2}$, 1 and 2 grain tablets.

Armour's Surgical Catgut Ligatures are smooth, strong and thoroughly sterile; 60-inch lengths, plain and chromic, sizes Nos. 000 to 4, inclusive.

WE have some new literature on Corpus Luteum, Pituitary Liquid and Thyroids that we shall be pleased to forward to physicians that are interested.

ARMOUR AND COMPANY
CHICAGO

Grandview Sanitarium

KANSAS CITY, KANSAS

The Grandview Sanitarium was completely destroyed by fire; Fifteen years active work in the sanitarium business enabled us to know our needs for the future. We have planned, built and completed what we believe to be an ideal place and are open and ready for business. Thanking our friends for their patronage in the past and assuring you we are prepared to give as good service as can be had in any sanitarium, we remain,

Very truly yours,

S. S. GLASSCOCK, M.D., Res. Supt.

A. L. LUDWICK, A.M., M.D., Asst. Supt.

EDITH GLASSCOCK, B.S.

Business Manager

Office 910 Rialto Bldg., Kansas City, Mo.

STATEMENT OF THE OWNERSHIP, MANAGEMENT, CIRCULATION, ETC.

Required by the Act of Congress of August 24, 1912, of the Journal of the Kansas Medical Society Published Monthly at Topeka, Kansas, for April 1, 1919.

State of Kansas, County of Shawnee, ss.

Before me, a notary public in and for the state and county aforesaid, personally appeared W. E. McVey, who, having been duly sworn according to law, deposes and says that he is the editor of the Journal of the Kansas Medical Society and that the following is, to the best of his knowledge and belief, a true statement of the ownership, management (and if a daily paper, the circulation), etc., of the aforesaid publication for the date shown in the above caption, required by the Act of August 24, 1912, embodied in Section 443, Postal Laws and Regulations, printed on the reverse of this form, to wit:

1. That the names and addresses of the publisher, editor, managing editor, and business managers are:

Name of	Post Office Address
Publisher—W. E. McVey, under direction of the Council of the Kansas Medical Society	Topeka, Kansas
Editor—W. E. McVey	Topeka, Kansas
Managing Editor—None.	
Business Manager—None.	

2. That the owners are: (Give names and addresses of individual owners, or, if a corporation, give its name and the names and addresses of stockholders owning or holding 1 per cent or more of the total amount of stock.)

Kansas Medical Society, Dr. Chas. S. Huffman, Columbus, Kansas, President; Dr. J. F. Hassig, Kansas City, Kansas, Secretary; Dr. L. H. Munn, Topeka, Kansas, Treasurer.

3. That the known bondholders, mortgagees, and other security holders owning or holding 1 per cent or more of total amount of bonds, mortgages, or other securities are: (If there are none, so state.) None.

4. That the two paragraphs next above, giving the names of the owners, stockholders, and security holders, if any, contain not only the list of stockholders and security holders as they appear upon the books of the company but also, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting, is given; also that the said two paragraphs contain statements embracing affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner; and this affiant has no reason to believe that any other person, association, or corporation has any interest direct or indirect in the said stock, bonds, or other securities than as so stated by him.

5. That the average number of copies of each issue of this publication sold or distributed, through the mails or otherwise, to paid subscribers during the six months preceding the date shown above is (This information is required from daily publications only).

W. E. McVEY, Editor.

Sworn to and subscribed before me this 27th day of March, 1919.

(Seal)

W. H. RILEY,
Notary Public.

(My commission expires March 5, 1921.)



We Hide The Bran In Flavory Flakes of Wheat

That is wise — is it not?

Thus we make bran food inviting. In Pettijohn's Food and Pettijohn's Flour it can be served in countless dainty ways.

Doctors asked us to make these foods for people who need bran daily, and who don't like clear bran.

Now many thousands of people constantly serve and enjoy them.

Pettijohn's

Rolled Wheat — 25% Bran

A breakfast dainty whose flavory flakes hide 25 per cent of bran.

Also Pettijohn's Flour — 75 per cent fine patent flour, 25 per cent bran. Use like Graham flour in any recipe.

(3073)

THE JOURNAL

of The

Kansas Medical Society

Vol. XIX

TOPEKA, KANSAS, JUNE, 1919

No. 6

Perforated Lung Following Broncho-Pneumonia

F. A. TRUMP, M.D., Ottawa

Read at the Annual Meeting of the Kansas Medical Society held at Ottawa, Kansas, May 7 and 8, 1919.

Following the epidemic of influenza and pneumonia at the base hospital, Camp Beauregard, practically all the possible pneumonia complications were encountered. Probably the most interesting as well as one of the rarest, and one which was reported from very few camps, was the perforated lung.

Two cases of spontaneous closed pneumothorax and seven cases of subcutaneous emphysema were encountered as a result of perforated alveoli. Of this number, one case of pneumothorax and three cases of emphysema recovered. Total number of pneumonia cases was 1,370. How many other cases may have had alveolar perforations and developed simply an "air cavity" we are unable to tell, although it is probable that it happened in a good many instances. In several patients radiographed for other purposes air cavities were noted.

As to the mechanism, it is not probable that the violent coughing was the causative factor, as severe coughing was not the rule in some of those cases, especially one pneumothorax in which the coughing was practically nil, while those patients having the worst paroxysms did not develop ruptured alveoli. More likely it would seem to be due to the virulence of the infection causing, as we saw by autopsy, practically necrotic lung tissue in many cases. During the actual pneumonia the exudate into the alveoli acted as plugs or splints to the necrotic tissue until the resolution

began, then the plug being removed, any moderate cough would "blow out" the alveolus. In fact this proved to be the time in which all of our cases appeared. Then after an opening was made into the interstitial tissue the air dissected its way, following the blood vessels through the mediastinum and eventually to the subcutaneous tissues, as explained by Captains Berkley and Coffin of Camp Lewis in their excellent paper on the same subject, or, as is possible, forcing its way directly through the visceral pleura into the thoracic cavity.

The pneumonia in these cases was no different from the others, merely representative of the entire epidemic which was practically always a massive broncho-pneumonia. Entire lobes were apparently consolidated but on section small areas of normal alveoli could be found here and there and different stages of consolidation. An interesting fact also is that the Type IV pneumococcus was found in over 75 per cent of the cases. All of the perforated lung cases were Type IV except one case which was Type III.

EMPHYSEMA

All degrees of subcutaneous emphysema were encountered, from a small area about the clavicle to the extensive ones involving face, neck, arms, trunk, and genitalia. In every case the emphysema was first noticed above one clavicle and disappeared at the same point in those recovering. The patients complained of no pain or ill feeling from the air beneath the skin and no inflammatory reaction resulted from its presence there.

History of one case follows: Number

22970, drafted man 21 years old, carpenter, moderate habits in regard to alcohol. Family history negative. Usual diseases of childhood. Pneumonia in 1913. October 1, influenza. October 7, bronchopneumonia developed in the left lower lobe, became delirious at once and very toxic, temperature not high, pulse weak and thready. October 13 the presence of air under the skin was detected above the clavicle and left side of neck, at the same time signs of resolution were found in places in the left lower lobe. The air quickly dissected its way down the left side to the waist, extending from sternum to post-axillary line, also down the left arm to the wrist. October 16, temperature normal and patient felt very good, emphysema disappearing. October 20, air all gone from beneath the skin except small spot size of half dollar over left clavicle which disappeared entirely two days later. Patient made an uneventful recovery.

PNEUMOTHORAX

Of the two cases here, one recovered. In one patient it was located on the left, in the other it was on the right side. The pneumonia in neither was of unusual severity and in one cough was practically nil. One patient had a chill a few hours before the perforation was discovered, otherwise there was no complaint, signs of shock or other evidence that might be interpreted as the moment of the accident. Both patients complained of pain and a sense of constriction about the thorax. Following is the history of the case recovering:

Number 20973, drafted man 23 years of age, farmer, does not use alcohol, family history negative, usual diseases of childhood, typhoid fever at age of 13, malaria 1916, denies venereal diseases. September 27 took influenza. October 4 developed bronchopneumonia, entire left lung. Pneumococcus Type III. Patient progressed favorably and on October 25 temperature was practically normal and chest was clear with the exception of a few spots of dullness in the left lung. Octo-

ber 26, complained of severe pain and constriction of chest. Chest Findings—Apex beat to the right of the sternum directly beneath the right nipple, mediastinal contents pushed over to the right. Left chest entirely fixed, hyperresonant except to the inner side of the lower lobe, which was flat. Tactile and vocal fremitus absent over hyperresonant portion. Cough produced peculiar metallic tinkling. Coin test positive. Radiograph verified the diagnosis of pneumothorax. October 30, signs of fluid in the chest and succussion. Thoracentesis resulted in 10 c.c. of dirty yellow fluid being removed. Rib resected and suction apparatus applied. Patient made an uneventful recovery. Chest examination and radiograph now show heart normal in outline and position. Both lungs functioning and equally resonant. Patient in exceedingly good health.

—————R—————

Treatment of Infected Wounds

J. S. SUTCLIFFE, M.D., Iola

Read at the Annual Meeting of the Kansas Medical Society held at Ottawa, Kansas, May 7 and 8, 1919.

I wish to call your attention to a method of dressing for infected wounds, as well as to condemn the use of powders and dry dressing.

The first object to be obtained in any infected wound is drainage. If powders and dry dressings are applied, the serum mingles with the powder, which forms a seal and closes up the drainage, the result being, for instance, on the finger or hand, the infected lymph no longer being able to escape through the wound, is taken up by the lymphatic vessels, producing an infection along the course of the vessels, which is characterized by the red and inflamed condition of the lymphatic vessels, extending up the arm, and later involving the axillary glands. This condition can very readily be prevented by the method which I suggest, and is as follows: For instance, the patient has had his finger crushed, and the wound has been dressed with powder and dry dressing, which we so frequently see. After 24 to 48 hours the finger is swollen and very painful, the

stitches, if any have been put in, have torn through the skin and a foul discharge exudes. To guard against this condition, cleanse the wound with soap and water. (I frequently use gasoline where the hand is very greasy or dirty, after which I usually use a bichloride solution, which should be warm.) The finger should then be wrapped with gauze thoroughly saturated with the bichloride solution, and then covered with rubber dam. This is the point to which I wish to draw your special attention: In 24 hours after applying the above dressing, the patient will return presenting the following condition: The finger, instead of being swollen, red and painful, will be shrunken, the skin corrugated, resembling the hands of a woman after doing a day's washing. The redness has disappeared, in its place is pallor, the pain which was due to the swelling is entirely dispelled, never to return so long as this method of dressing is kept up. The exudatory serum will keep the dressing moist, consequently the dressing will not adhere to the wound.

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Proceedings of the Fifty-Third Annual Meeting of the Kansas Medical Society, Held at Ottawa, Kansas, May 7-8, 1919

MEETING OF THE COUNCIL

The Council of Kansas Medical Society met in the G. A. R. room at the court house May 7, 1919, at 9 a.m. Those present were the president, Dr. W. S. Lindsay, Acting Secretary Dr. L. F. Barney, Treasurer Dr. L. H. Munn, and the following Councillors: Dr. C. C. Goddard, Dr. H. N. Moses, Mr. W. F. Sawhill, Dr. P. S. Mitchell, Dr. C. S. Kenney, Dr. E. S. Edgerton, and Dr. J. A. Dillon. The editor of the Journal, Dr. W. E. McVey, was also present.

The reports of the secretary and treasurer were read and referred to the auditing committee.

It was moved and carried that all members of the society returning from military service before April 1, 1919, shall pay dues for the current year, but those

returning after that time shall have their dues remitted.

A resolution to re-district the state was recommended for adoption.

A motion was made and carried whereby the constitution with the new resolutions that have been adopted, be revised and published for the benefit of the society.

A committee of two, consisting of Drs. Dillon and Moses, was appointed to audit the books of the secretary and treasurer.

Council adjourned.

GENERAL SESSION

The regular session of Kansas Medical Society convened at the appointed hour to listen to the president's address and the various scientific papers on the program, with discussions of same.

Dr. Allen B. Kanavel and Dr. E. H. Ochsner, both of Chicago, and men of national reputation, delivered very interesting lectures. Mr. John G. Bowman, also of Chicago, and director of the American College of Surgeons, gave a very fine talk on Hospital Standardization.

Dr. J. F. Binnie, of Kansas City, Mo., who organized Base Hospital No. 28 and who has just recently returned from overseas, contributed much to the interest of those present by telling of the handling of patients at the front.

A number of our members who have recently returned from military service presented papers on their war experiences which added much to the interest of the meeting.

The program carried out was as follows:

President's address, Dr. W. S. Lindsay, Topeka.

"Treatment of Infected Wounds," Dr. J. S. Sutcliff, Iola.

"Perforated Lung Following Bronchopneumonia," Dr. F. A. Trump, Ottawa.

"Prostatectomy—Pre and Post-Operative Management of Cases," Dr. L. O. Nordstrom, Salina.

"Empyema," Dr. W. P. Callahan, Wichita.

"A Study of 750 Obstetric Cases in Private Practice," Dr. E. A. Reeves, Kansas City.

"My Experience at the Front," Dr. J. C. Missildine, Parsons.

"Strictures of the Eustachian Tubes," Dr. E. C. Button, Great Bend.

"Clinical Data vs. Laboratory Findings; the Correlation of Contradictory Data in Internal Medicine," Dr. C. F. Menninger, Topeka.

"The Acute Abdomen," Dr. W. E. Mowery, Salina.

"Fractures of the Femur," Dr. R. C. Lowman, Kansas City.

"Differential Diagnosis of Mental Diseases," Dr. M. L. Perry, Topeka.

"Eye Examination as Practiced in the Army," Dr. G. A. Landes, Parsons.

"Personal Experience with Gas in the St. Mihiel and Argonne-Meuse Drives," Dr. R. H. Meade, Kansas City.

"Some Considerations in the Treatment of Purulent Appendicitis," Dr. T. A. Jones, Hutchinson.

Wednesday Evening

"Hospital Standardization," Mr. John G. Bowman, Chicago.

"The Treatment of Flat Foot," Dr. Edward H. Ochsner, Chicago.

Thursday Morning

The entire program for the morning was furnished by the School of Medicine, University of Kansas.

"Encephalitis Lethargica," Dr. Andrew Skoog.

"The Responsibility of the State in Caring for the Defectives," Dr. L. L. Uhls.

"The Etiology of the Recent Influenza Epidemic," Dr. Ralph H. Major.

"The Management and Treatment of Syphilis," Dr. Nelse Ockerblad.

"The Diagnosis of Hyperthyroidism," Dr. Arthur E. Hertzler.

"Non-Specific Therapy," Dr. W. A. Myers.

"The Role of the Laboratory in the Diagnosis of Venereal Disease," Dr. Wilbur A. Baker.

"Myocardial Disease and Cholelithiasis," Dr. M. T. Sudler.

Thursday Afternoon

"Urethral Strictures," Dr. E. M. Myers, Salina.

"Empyema," Dr. T. J. Carter, Wichita.

"Experiences in Spinal Cord Surgery," Dr. Allen G. Kanavel, Chicago.

"Handling of Patients at the Front," Dr. J. F. Binnie, Kansas City, Mo.

"Nasal Accessory Sinusitis," Dr. L. B. Spake, Kansas City.

"Some Medical Reminiscences," Dr. H. Michiner, Wichita.

"Child Welfare," Dr. Lydia A. DeVilbiss, Topeka.

The following resolution was passed by the regular session:

"Resolved, that the Kansas Medical Society in fifty-third annual session assembled, favors the making of thorough physical training in all the public schools of the state a part of the course of instruction, thus better fitting the pupils, not only for the duties of civil life but making them better able to serve their country promptly in case of any future national emergency."

A motion was made that the chairman appoint a committee of five which shall devise and report at the next meeting of the Kansas Medical Society, a modern method for determining the sanity of an individual and his commitment to the state hospital for care and cure. Motion carried.

The regular session adopted the following resolutions:

"Whereas, the Kansas State Board of Health in co-operation with the United States Public Health Service is conducting a vigorous campaign against venereal diseases, and

"Whereas, physicians are particularly interested in that part of the campaign which relates to the diagnosis and treatment of venereal diseases, and

"Whereas, the Kansas State Board of Health has arranged to provide facilities for free laboratory examinations of specimens for the diagnosis of venereal diseases, to furnish free arsphenamine for indigent cases, and has adopted the policy of establishing clinics for the treatment of venereal diseases in the larger cities,

"Therefore be it resolved, that the Kan-

sas Medical Society heartily endorse the campaign being waged by the State Board of Health and especially that part of the campaign which provides facilities for the diagnosis and treatment of venereal diseases, and

"Be it further resolves, that the Kansas Medical Society call upon all physicians in the state to co-operate with the health authorities in their efforts to combat venereal diseases, and

"Be it further resolved that the local authorities in the larger cities of the state be urged to provide for the establishment of clinics in co-operation with the State Board of Health, and

"Be it further resolved that copies of these resolutions be sent to the Surgeon General of the Public Health Service, the secretary of the State Board of Health, the editor of the Journal of the American Medical Association, and the editor of the State Medical Journal, with a request that they be published."

MEETING OF THE HOUSE OF DELEGATES

The meeting was called to order by the president, Dr. W. S. Lindsay, at 4 p.m., Wednesday, May 1.

On motion of the House, the reading of the minutes of the last meeting was dispensed with. Next in order of business was the report of the different officers.

Secretary's Report

I desire to submit the following report for the year ending May 1, 1919:

Financial Report

Balance on hand May 1, 1918...\$.....

Divided as follows:

Medical defense\$2,003.37

General fund 5,328.35

Total\$ 7,331.72

Amount received from all sources
for year ending May 1, 1919:

Dues from members...\$3,818.00

Rec'd from editor.... 1,122.08

Interest 125.84

Total amount received\$ 5,065.92

Grand total\$12,397.64

Amount paid out for year ending
May 1, 1919:

Medical defense\$ 759.51

General fund 1,893.24

Total\$ 2,652.65

Balance on hand May 1, 1919...\$ 9,744.99

Statement of how the two funds

now stand:

Medical defense\$2,890.65

General fund 6,854.34

Total\$ 9,744.99

The condition of our society, on account of having been torn to pieces by the war, is not as satisfactory as it was previous to that time. While our membership remains practically the same as it has been for the last two years (about 1,500), yet our income has been considerably reduced owing to the fact that the dues of those in the service have been remitted. But these are rapidly returning and from all indications the next year will put us back to a normal standing.

Again this year, as last, I wish to recommend that the county societies be more thoroughly organized. In many of the counties they are completely disorganized and it has been impossible for the secretary to get any information or communication from these localities and we would suggest that the councillors stimulate their activities and get all of the members of the profession who are eligible back into the society. During this time an unusually large number of physicians have changed their location and it will be well to look after these. We have received a communication from the American Medical Association asking what our societies are doing in regard to these men, stating that it has been reported to them that in a few instances county medical societies have apparently objected to physicians endeavoring to locate within the jurisdiction of these societies—at least they have refused to consider applications for membership submitted by these physicians, and it is alleged have objected to these physicians affiliating with the staffs of, or undertaking to treat patients in local hospitals.

During the past two years it has been the pleasure of the society to aid in many

ways, especially in co-operation with the parent organization, the American Medical Association, along various lines of war activities. The past few years have shown the need for constant and active medical organization, and during the reconstruction period this will be just as necessary as in the past, and as our members will not be so scattered we should be able to do even more than in the past.

The preparation of the program for this meeting has been unusually difficult; for those who remained at home have been so overworked that in most cases it has been hard to get them interested in the meeting and in many instances it has been impossible to get responses from extensive territory. However, many have responded most graciously and have come forward under trying circumstances.

We wish to acknowledge the gratitude that the society, and particularly the secretary, feels is due them. I wish to especially thank our worthy president, who has been ready at all times to do all that it was possible for him to do, and also our editor, who has ever manifested the same willingness in all matters pertaining to the society.

Respectfully,

L. F. BARNEY
Acting Secretary.

The report was accepted and placed on file.

Treasurer's Report

To the House of Delegates:

I desire to submit the following report for the year ending May 4, 1919:

Balance cash on hand May 1,
1919\$ 7,331.72

Divided as follows:

General fund\$5,328.35
Medical defense 2,003.37
Rec'd from secretary. 4,940.08
Rec'd for interest.... 125.84
Total amount cash received...\$ 5,065.92

Total amount of cash for year
ending May 5, 1919.....\$12,397.64
Cash paid out to May 5, 1919:
General fund\$1,893.24

Medical defense 759.41
Total expenditures\$ 2,652.65
Balance on hand May 5, 1919...\$ 9,744.99
Of this amount we invested in
Liberty Loan:
Second issue\$3,000.00
Third issue 1,500.00
Total am't in Liberty Loan...\$ 4,500.00

Bal. in bank subject to check...\$ 5,244.99

L. H. MUNN
Treasurer.

Report accepted and placed on file.

Editor's Report

House of Delegates, Kansas Medical Society.

Sirs: Your editor respectfully submits for your consideration the following report of the financial condition of the Journal for the fiscal year ending May 1:

Subscriptions (1,400) from members\$2,800.00
Subscriptions from non-members. 33.50
Receipts from advertising 2,962.46
Receipts from sales 33.72

\$5,769.68

Cost of publication 3,581.60

Net earnings\$2,188.08

And the following statement of the account of the editor with the society:

Rec'd from treasurer ..\$1,000.00
Rec'd from advertising. 2,962.46
Rec'd subscriptions ... 33.50
Rec'd other sources ... 272.74

\$4,268.70

Expended for printing
Journal\$1,704.64
Expended for other
printing 43.00
Expended for mailing,
express and postage. 160.34
Expended for miscellaneous,
including paper 473.60
Expended for salaries.. 1,200.00

\$3,581.60

\$ 687.10

During the past year we have had much difficulty in keeping our mailing list up to requirements. We have tried to send the Journal regularly to men in the army, but have found that it was practically impossible to keep up with their frequent changes of address. Whenever we could ascertain the assignment of men sent overseas, we mailed the Journal to them, but very few of the copies mailed succeeded in reaching those to whom they were addressed.

Occasionally a notice was received from one of the cantonments to the effect that the person to whom the Journal was addressed had gone to some other cantonment, but in many such instances the new location would not be mentioned. Occasionally a bundle of undelivered Journals was returned to us with no information as to the location of the addressees.

With the demobilization of the army and the return of medical officers to civil life, our difficulties are multiplied; our only source of information in regard to the return of members has been the lists published in the Journal of the American Medical Association. We have found that a good many are seeking new locations and we regret to say that we have failed to reach a good many of these who have returned. It would modify this task if the secretaries of county societies would notify the Journal office of their returned members and any changes of location that may be made.

During the very stringent war restrictions affecting all kinds of industry the supply of print and book paper was most zealously guarded, and except for the fact that we had provided ahead for such a possible emergency, the size of the Journal would have been considerably reduced. Under the circumstances we feel that the showing we have made for the past year is fully as good as could be expected and much better than many similar publications have been able to make.

Very respectfully,

W. E. McVEY.

The report was accepted and placed on file.

Next in order of business was the reports of the councillors from the various districts.

Dr. L. W. Shannon, Councillor for the First District, Dr. P. S. Mitchell, Councillor for the Third District, and Dr. O. P. Davis, Councillor for the Fourth District, made verbal reports of the condition of their respective districts, which are as good as could be expected, considering the handicaps of war and influenza.

Dr. C. C. Goddard, Councillor for the Second District, gave the following report:

"No visits were required during the past year as all seemed to be doing as well as the war would allow. We were called upon to complete a roster for army purposes and were finally unable to get as good a report as could have been had, owing to changes of orders from state and national headquarters. There seemed to be a conflict of thought, which was reasonably to be expected. The incompleteness was due to orders countermanding answers being sent to state headquarters by councillors and diverting some to Washington direct from individual doctors; otherwise the returns would have been very gratifying, and really are, so far as original orders were carried out. It is only fair to say that nearly all of those answering 'No' to questionnaire were for physical disability or age."

The following report was given by Dr. C. S. Kenney, Councillor for the Ninth District.

To the House of Delegates: The Ninth District, of which I have the honor of being Councillor, comprises the counties of Cheyenne, Rawlins, Decatur, Norton, Phillips, and Smith. All are accessible by Kansas railroads, except Cheyenne and Rawlins. The proposed changes in the district will add Thomas and Sherman counties, which are on the Rock Island railroad. Two good auxiliary societies are maintained, viz., Smith County with sixteen members and Decatur-Norton with twenty-two members.

An effort was made to create two more societies, one in Phillips County and one in the west end of the district, composed of the physicians of Cheyenne and Rawlins counties, but it was thought best for the present to keep their memberships in the two large, well organized and active societies already established in the district.

The district suffered as did all others last year from the war activities and influenza, yet with this handicap the societies had a very profitable year.

The following is a detailed report of the conditions in the various counties for 1918, considering physicians only who are eligible or in active practice:

Cheyenne County—

Number physicians	4
Number members of society...	2
Number in service	0
Per cent in society	50
Per cent in service	0

Rawlins County—

Number physicians	6
Number in society	1
Number in service	1
Per cent in society	16 $\frac{2}{3}$
Per cent in service	16 $\frac{2}{3}$

Decatur County—

Number physicians	8
Number members of society..	4
Number in service	3
Per cent of members	50
Per cent in service	37 $\frac{1}{2}$

Norton County—

Number physicians	14
Number members of society...	8
Number in service	6
Per cent of members	57
Per cent in service	43

Phillips County—

Number physicians	18
Number members of society...	7
Number in service	1
Per cent of members	39
Per cent in service	6

Decatur-Norton Counties—

Number physicians	22
Number members	12
Number in service	9

Per cent members55

Per cent in service41

Smith County—

Number physicians19

Number members16

Number in service 4

Per cent members84

Per cent in service21

District—

Number physicians69

Number members38

Number in service15

Per cent members55

Per cent in service22

These reports are accurate, so far as I have been able to determine, and show a fair average.

Respectfully submitted,

C. S. KENNEY.

Dr. D. R. Stoner, Councillor for the Tenth District, gave the following report: To the Officers and Members of the Kansas Medical Society:

As Councillor for the Tenth District, I beg to submit the following report for 1918:

The Tenth District includes the counties of Logan, Thomas, Gove, Sheridan, Graham, Trego, Sherman and Wallace.

The following counties have been visited the past year: Wallace, Logan, Gove, Trego, Sheridan and Graham.

We have only the one district medical society, the Tri-County Society, in this district, as it is impossible to organize the individual counties as in the past. On account of the large percentage of physicians enlisting and volunteering in the Medical Reserve Corps and excessive work of various draft boards of the district and the extreme epidemics of the last year, only one meeting was held, although a number of attempts were made.

As in the past, all members who have enlisted in the Medical Reserve Corps have been carried and are this year as members in good standing in the district society. Some of our members are yet in France, some just recently discharged, a number have left the district permanently,

new ones located and several retired on account of physical disability.

A large percentage of the physicians are members of the district and state societies, as will be seen by the following summary:

Practicing physicians in Tenth Councillor District	35
Members of Tri-County and Kansas Medical Society	24
Eligible for membership	33
Members in army service, past year....	13
Removals from the district during past year	2
Present medical men in Tenth District..	22
Retired from practice past few months..	2
Deaths in 1918 (Dr. G. E. Haughey, Wakeeney)	1

Would suggest that there be a complete reorganization of the district medical society at once and the officers and your new councillor be instilled with renewed energy in replacing the Tenth District in its former place as having the highest percentage of physicians as members of the local and state societies of any of the councillor districts.

Respectfully submitted,

D. R. STONER.

It was moved and carried that the proposed amendments to the constitution be adopted.

PROPOSED AMENDMENTS TO THE CONSTITUTION

Notice is hereby given, in accordance with Article XIV of the Constitution, of certain proposals to amend the Constitution and By-Laws of the Kansas Medical Society.

It is proposed to amend Article IV to read as follows:

Article IV—Composition of the Society

Sec. 1. The Society shall consist of officers, councillors, delegates, members and guests.

Sec. 2. The officers of this society shall be a president, three vice-presidents, a secretary and a treasurer, to be elected by the House of Delegates, for such terms of office as hereinafter provided.

Sec. 3. The councillors shall be twelve

in number, to be elected by the House of Delegates, one from each Councillor District, and to serve for such terms as hereinafter provided.

Sec. 4. Delegates shall be those members who are elected in accordance with this constitution and by-laws to represent their respective component societies in the House of Delegates of this society.

Sec. 5. The members of this society shall be the members of the component county medical societies or other societies approved by the council.

Sec. 6. Any distinguished physician not a resident of this state, who is a member of his own state society, may become a guest during any annual session on invitation of the officers of this society, and shall be accorded the privilege of participating in all of the scientific work for that session.

It is proposed to add the following, which shall be Article V:

Article V—Councillor Districts

There shall be twelve Councillor Districts, comprised as follows:

First District: Nemaha, Brown, Doniphan, Jackson, Atchison, Jefferson, Marshall, Pottawatomie and Riley Counties.

Second District: Leavenworth, Wyandotte, Johnson, Douglas, Franklin, Miami, Coffey, Anderson and Linn Counties.

Third District: Woodson, Allen, Bourbon, Wilson, Neosho, Crawford, Montgomery, Labette, Cherokee, Elk and Chautauqua Counties.

Fourth District: Shawnee, Wabaunsee, Geary, Osage, Morris, Lyon and Chase Counties.

Fifth District: Rice, McPherson, Marion, Harvey, Reno, Stafford, Pratt and Kiowa Counties.

Sixth District: Kingman, Cowley, Sumner, Harper, Barber, Sedgwick, Butler, Greenwood, Clark and Comanche Counties.

Seventh District: Rooks, Osborne, Jewell, Mitchell, Republic, Cloud, Washington and Clay Counties.

Eighth District: Lincoln, Ellsworth, Ottawa, Saline and Dickinson Counties.

Ninth District: Cheyenne, Rawlins, De-

catur, Norton, Phillips, Smith, Sherman and Thomas Counties.

Tenth District: Sheridan, Graham, Trego, Gove, Logan, Wallace, Ellis and Russell Counties.

Eleventh District: Barton, Rush, Pawnee, Edwards, Hodgeman, Ness, Lane, Scott, Wichita and Greeley Counties.

Twelfth District: Meade, Seward, Haskell, Stevens, Grant, Morton, Stanton, Ford, Gray, Finney, Kearney and Hamilton Counties.

It is proposed to change the present Article V to Article VII.

It is proposed to amend Article VI to read as follows:

Article VI—Council

The Council shall consist of the president, secretary and treasurer, ex-officio, and twelve councillors, one councillor to be elected by the House of Delegates from each councillor district. Besides its duties as mentioned in the by-laws, the Council shall constitute the finance committee of the House of Delegates. Five councillors shall constitute a quorum.

It is proposed to change the present Article VII to Article VIII and proposed to change the present Article VIII to Article IX.

It is proposed to change the present Article IX to Article X and amend it to read as follows:

Article X—Terms of Office

Sec. 1. The term of office of the president, vice-presidents and treasurer shall be for one year. The term of office of the secretary and the councillors shall be for three years. All of these officers shall serve until their successors are elected and installed.

Sec. 2. The officers of this society shall be elected by the House of Delegates on the morning of the last day of the annual session, and no person shall be elected to any office who is not in attendance upon that annual session, and who has not been a member of the society for the past two years.

It is proposed to change Section 4 of

present Article IX to Article XI—Defense Board.

It is proposed to change present Articles X, XI, XII, XIII, and XIV to Articles XII, XIII, XIV, XIV, and XIV, respectively.

It is proposed to change Section 9, Chapter IV of the By-Laws by striking out the following: "Divide the state into Councillor Districts, specifying what counties each district shall include, and,"

It is proposed to change Section 3, Chapter VI, by striking out the word "state" in the last line.

The report of the standing committees was called for, but no reports were made except that of Dr. W. S. Lindsay for the Committee on Public Policy and Legislation.

Dr. O. P. Davis, chairman of the Medical Defense Board, made a report for same.

To the House of Delegates:

The Defense Board begs to submit a report of its work during the past year. This work is well summarized in the subjoined report of the attorney of the board, Mr. E. D. McKeever, who, in the past year, as in the previous years of his service in such capacity, has most efficiently and successfully conducted the legal operations in behalf of the members who have had occasion to seek the assistance of the board.

The board has nothing to add to the report of the attorney further than to caution the members against losing interest in the defense feature of our society, now that the number of suits against members seems to be falling off. It is quite likely that someone will soon be complaining against this as an unnecessary expense, and proposing its discontinuance, and that too, doubtless, with a considerable following. Such has always been the history of similar undertakings. Even in private life, a man who has carried insurance against fire and accident for many years without any tangible return, will sometimes, in a spirit of retrenchment, discontinue such expense. But no one

pities him much if he soon afterward suffers painful loss; or if he is pitied, it is pity for his short-sightedness.

Let us diligently keep up this very successful and inexpensive co-operative feature of our organization. Let us strengthen it and reinforce it wherever we can, advertising it, boasting of it, and giving it the recognition it deserves on every possible occasion.

Report of the Medical Defense Board

Expenditures

Voucher No. 4. May 3, 1918—O. P. Davis, postage, etc.	\$ 2.00
No. 5. June 10—E. D. McKeever, services	47.79
No. 6. June 27—E. D. McKeever, salary	100.00
No. 7. June 27—E. D. McKeever, expenses and per diem.....	19.36
No. 8. Aug. 28—E. D. McKeever, salary	100.00
No. 9. Nov. 21—W. E. McVey, circulars	12.00
No. 10. Nov. 21—E. D. McKeever, salary	100.00
No. 11. Nov. 21—E. D. McKeever, expenses and per diem.....	23.26
No. 12. Dec. 31—E. D. McKeever, salary	100.00
No. 13. March 1, 1919—E. D. McKeever, salary	100.00
No. 14. April 12—Journal Kansas Medical Society, advertising....	55.00
No. 15. May 2—E. D. McKeever, salary	100.00
Total	\$759.41

Expenditures of Previous Years

1917.....	\$ 809.58
1916.....	777.45
1915.....	1,189.27
1914.....	1,254.95
1913.....	1,721.10
1912.....	895.80
Total.....	\$6,648.15

Total expenditures in history of

this board\$7,407.56

Respectfully submitted,

O. P. DAVIS, Chairman

D. R. STONER

Medical Defense Board.

Mr. Edwin D. McKeever, attorney for the Medical Defense Board, made the following report:

To the Defense Board of the State Medical Society.

Gentlemen: Since my last report there has been a lull in the trial of cases, occasioned apparently by the war, in which some of our members with suits pending against them have been serving their country and the cases have been dismissed.

Since my last report I have tried one case—the case of Paulich vs. Nipple in Crawford County. This suit had been once tried without my assistance and resulted in a hung jury. Dr. Nipple's local attorneys advised him to settle for \$750. In keeping with the spirit of our members not to settle anything, he declined to settle and asked me to defend him, which was entirely satisfactory to his local counsel. I tried this case and Judge Curran, at the close of the plaintiff's evidence, sustained my demurrer and rendered judgment for Dr. Nipple. Later, without any notice to me, Judge Curran set aside his judgment and granted a new trial, from which I appealed to the Supreme Court. The case was argued at the April term, and will be decided in a few days.

The case of McRoberts vs. Clopper in Wyandotte County has been dismissed. The plaintiff made an offer to dismiss this on a settlement of \$50. Dr. Clopper very properly refused to purchase the dismissal of this suit and also stood ready for trial, and the case was dismissed at the plaintiff's cost.

This illustrates the importance of standing pat in these cases and I recommend to the members of the profession that they follow the policy of Drs. Nipple and Clopper, and not get panicky and settle these cases—at least not without the consent of counsel. Many cases are brought with no intention of trying them, with the expecta-

tion that the doctor will get scared and settle them.

Your attorney for the first time since his connection with your defense board has settled a case. I have always had a fear of cases where the surgeon became so absorbed in the operation that he sewed up a sponge or piece of gauze inside his patient. There appears to be a good many cases of this kind in the law reports and generally there is not a chance to defend against them.

I had a case of a member who in some way left inside of the bowels of a patient a piece of gauze 16x4 inches long with a metal ring on the end. The patient afterwards had an operation and died. This looked like a good case to settle, both from a legal and moral standpoint, and when the bereaved husband agreed to accept his expenses in the sum of about \$1,000, I lost no time in paying it in behalf of the Physicians' Indemnity Association in which this physician was insured. This physician had a busy and successful practice and had never had an accident before. He was well pleased with the treatment he received and it cost the Defense Board nothing.

I recommend that the members of the State Medical Society avoid as far as possible mistakes of this kind, because they are bound to prove expensive.

I have a very exhaustive brief of medical cases and I find about ten or eleven cases of this character in my brief. This, of course, does not include the cases which have been settled and where judgment has been recovered without appeal. I think the surgeon in each case lost in the Appellate Court, showing that cases of this kind are expensive both to the patient and the surgeon or his indemnitor.

The following cases reported last year are still pending:

In the District Court of Saline County, Roberta Heck vs. W. E. Mowery and J. W. Neptune, \$10,000. This case was recently set for trial but the attorney, on account of other engagements, was unable to attend and it was continued. The plain-

tiff desired to drop the case, but the defendants insist on trying it and procuring judgment for their fees.

In the District Court of Crawford County, Paulich vs. F. E. Nipple, \$5,000, pending on an appeal in the Supreme Court on new trial granted plaintiff after judgment for defendant.

In the District Court of Reno County, B. Marriage vs. Drs. Gage and Hall, \$5,600. Nothing has been done in this case by the plaintiff for some time.

In the District Court of Allen County, D. D. Johnson vs. John Allen, \$3,732.71. This is a case where the attorney for the indemnity company does not need any assistance and I do not know what the status of the case is.

In the District Court of Neosho County, Anna Renner vs. J. C. Henderson and J. J. MacNamara, \$10,000. Dr. Henderson has been in military service and I have had no advices that he has been discharged. MacNamara, I am informed, has left the state.

In the District Court of Neosho County, John Renner vs. J. C. Henderson and J. J. MacNamara, \$10,000; same as above.

In the District Court of Wyandotte County, George Mitchell vs. J. J. Russell, \$5,000. This case was tried over a year ago and resulted in a hung jury. Nothing has been done by plaintiff since but continue the case.

In the District Court of Wilson County, Bert Stewart vs. J. W. McGuire, \$12,699.60. No move by plaintiff has been made in this case since last reported. I think Dr. McGuire is in the military service.

In the District Court of Mitchell County, Vietta Shaffer vs. Carl Brown, \$5,000. Nothing has been done in this case since the last report. Dr. Brown wrote me some time ago that he was about to enter military service and I regret to learn that he has since died while in such service.

In the District Court of Riley County, Brandenburg vs. Colt, \$10,000. This case was recently set for trial but the plaintiff's attorney was not ready and the case was

continued.

In addition to the above cases, the following cases have been filed since last report:

In the District Court of Montgomery County, J. Forman vs. C. C. Surver. This case was filed last October and the plaintiff seems to be permitting it to drag.

In the District Court of Allen County, Rainey vs. Dr. Smith and R. R. Neavitt. Dr. Neavitt is a member of our society and is in the military service and the case is awaiting his discharge, I suppose.

In the District Court of Montgomery County, Orin T. Tarr vs. H. L. Aldrich, \$7,930.50. This matter is being given careful attention.

In addition to the above cases there are several that have been threatened and I have been offered two or three myself, which I have of course declined and which have never been brought by any attorney.

As I am the father of the Physicians' Indemnity Association, I will be pardoned for again referring with pride to this institution. This association has grown steadily and in addition to its membership in this state has been admitted to four other states, which will place it on an equal basis with the best indemnity companies. The same high requirements as to membership are made in the other states as in this state, and no person can become a member who is not eligible to membership in his State Society. There is a surplus in the treasury of over \$10,000, and one case pending which is wholly without merit and which will probably never be tried. We have made one settlement in which we paid \$1,041 to avoid a certain loss.

Members of the profession in this state desiring indemnity can make no mistake in connecting themselves with this association, as it is a home institution. The premium is payable in two annual assessments of \$5 each and therefore is cheaper and more convenient than others, and the association is thoroughly dependable. I expect to give my personal attention to the defense of each case against members

in Kansas insured in this institution.

The admission of our association to the states of Iowa, Nebraska, Missouri and Oklahoma will insure a large and rapid growth, which will still further establish the association as a bulwark of efficient and complete protection against loss or expense, that may occur on account of malpractice suits.

Respectfully submitted,

EDWIN D. MCKEEVER.

On motion the work of the Medical Defense Board was commended by the House of Delegates.

Meeting adjourned.

MEETING OF THE HOUSE OF DELEGATES

The House of Delegates convened Thursday, May 8, 1919, at 9:00 a.m., and was called to order by the president, Dr. W. S. Lindsay.

A motion was made that a committee of three be appointed to take the matter of the representation of the medical profession up with the Historical Society at Topeka.

The roll call of the delegates was taken after which came the business of the election of the new officers for the coming year. The following were elected:

President, Dr. Elmer E. Liggett, Oswego.

Vice President, Dr. J. R. Scott, Newton.

Vice President, Dr. R. C. Lowman, Kansas City.

Vice President, Dr. J. G. Dorsey, Wichita.

Treasurer, Dr. L. H. Munn, Topeka.

Delegates to the American Medical Association: Dr. C. S. Huffman, Topeka; Dr. W. S. Lindsay, Topeka; Dr. R. J. Morton, Green.

Motion was made and carried that two councillors hold over for one year so that we will then have four elected each year. Dr. C. S. Kenney, Councillor of the Ninth District, and Dr. J. A. Dillon, Councillor of the Eleventh District, were chosen to hold over. Dr. W. F. Fee of Meade was elected councillor of the Twelfth District.

The standing of the Council is as follows:

First District—Dr. L. W. Shannon, Hiawatha; term expires 1921.

Second District—Dr. C. C. Goddard,

Leavenworth; term expires 1921.

Third District—Dr. P. S. Mitchell, Iola; term expires 1922.

Fourth District—Dr. O. P. Davis, Topeka; term expires 1920.

Fifth District—Dr. J. J. Brownlee, Hutchinson; term expires 1920.

Sixth District—Dr. E. S. Edgerton, Wichita; term expires 1922.

Seventh District—Dr. W. F. Sawhill, Concordia; term expires 1921.

Eighth District—Dr. H. N. Moses, Salina; term expires 1921.

Ninth District—Dr. C. S. Kenney, Norton; term expires 1920.

Tenth District—Dr. D. R. Stoner, Ellis; term expires 1922.

Eleventh District—Dr. J. A. Dillon, Larned; term expires 1920.

Twelfth District—Dr. W. F. Fee, Meade; term expires 1922.

REPORT OF AUDITING COMMITTEE

We, the Auditing Committee, find that the books of the secretary and treasurer are correct with the exception of Voucher No. 58, amount \$72, which should be changed in number and changed to the coming year's account.

H. N. MOSES
J. A. DILLON.

MEETING OF THE COUNCIL

The meeting was called to order by the newly elected president, Dr. E. E. Liggett. Those present were the president, Dr. E. E. Liggett; acting secretary, Dr. L. F. Barney; editor, Dr. W. E. McVey; and councillors, Dr. H. N. Moses, Dr. J. A. Dillon, Dr. C. S. Kenney, Dr. W. F. Sawhill, Dr. P. S. Mitchell, Dr. C. C. Goddard and Dr. E. S. Edgerton.

It was moved and carried that the Necrology Committee have a place on the program of the next regular session of the Kansas Medical Society.

It was decided that a memorial tablet be placed in the Kansas Medical School in honor of Dr. J. E. Sawtell.

A motion was made that the Necrology Committee draw up resolutions and that they be sent to the family and placed on

record of the society by the secretary. Motion carried.

It was further moved that the president of the Kansas Medical Society be a member, ex-officio, of the Necrology Committee. Carried.

The meeting for next year was taken up and Hutchinson was chosen as the place for 1920.

It was moved and carried that the bills of the secretary for expenses be paid.

A motion was made that the salary of the secretary be brought up at the mid-year councillors' meeting, the change to be retroactive from May 1, 1919. Motion carried.

The editor's salary was increased to \$1,500. Dr. McVey, the editor, objected, but was overruled.

Dr. D. R. Stoner, retiring member of the Medical Defense Board, was re-elected to serve until 1922.

Motion was made and carried that a committee of three be appointed to act in accordance with Section 6, Chapter VII of the Constitution and By-Laws of the Society. Dr. O. P. Davis, Dr. C. C. Goddard and Dr. L. W. Shannon were appointed to act with the president.

The following resolution was passed by the Council:

Resolved, that the organized medical profession of Kansas vigorously protests against the unfair discrimination imposed upon them by the federal government, known as the Anti-Narcotic tax, thus paralyzing them for performing their duty to the public in regard to the Anti-Narcotic law.

Be it further resolved, that this resolution be transmitted to our senators and representatives in congress.

Council adjourned to meet at the call of the president.

L. F. BARNEY,
Acting Secretary.

—————R—————

Progress is costly, and especially in medicine. We are all willing to enjoy the fruits of progress, but few are willing to pay the price.

THE JOURNAL

of The

Kansas Medical Society

W. E. McVEY, M.D. - - Editor

ASSOCIATE EDITORS—L. W. SHANNON, C. C. GODDARD, P. S. MITCHELL, O. P. DAVIS, J. J. BROWNLEE, E. S. EDGERTON, W. F. SAWHILL, H. N. MOSES, C. S. KENNEY, D. R. STONER, J. A. DILLON, W. F. FEE.

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LIST OF OFFICERS—President, E. E. Liggett, Oswego; Vice Presidents, J. R. Scott, Newton; R. C. Lowman, Kansas City; J. G. Dorsey, Wichita; Secretary, J. F. Hassig, Kansas City; Treasurer, L. H. Munn, Topeka.

COUNCILLORS—First District, L. W. Shannon, Hialeah; Second District, C. C. Goddard, Leavenworth; Third District, P. S. Mitchell, Iola; Fourth District, O. P. Davis, Topeka; Fifth District, J. J. Brownlee, Hutchinson; Sixth District, E. S. Edgerton, Wichita; Seventh District, W. F. Sawhill, Concordia; Eighth District, H. N. Moses, Salina; Ninth District, C. S. Kenney, Norton; Tenth District, D. R. Stoner, Quinter; Eleventh District, J. A. Dillon, Larned; Twelfth District, W. F. Fee, Meade.

Visions

Whether we regard them as prophetic, the product of an unusually vivid imagination, or the conclusions of a constructive genius, it must be admitted that many of the achievements of modern times are the realization of what were formerly regarded as visions.

Just as the student of archaeozoic relics may, from a few bones and fragments of bones, build up the framework and the outward form of the extinct animal from which they came, so there are men who, from an assembly of facts, conditions and tendencies, may construct for our entertainment—for our guidance if we would have it so—a perfect plan of our future mode of life.

One who has passed the meridian of life should be able to visualize, with a fair degree of accuracy, the future status of that particular science or profession to which the best part of his life has been devoted. Few of us do so. In fact, we are continually startled by the new conditions constantly presenting in our particular fields of activity. We are unprepared for the progress of events that our experience should teach us to expect.

The rapid and continued progress of

medicine has made evident the need for some reconstructive program for its practice, but the great war and the assembly of nearly a third of the active men in our profession, their specialized training and co-ordinate grouping for the particular needs of the government service, have accentuated that need. It is not strange then that the imaginative minds have found a stimulus for renewed activity, and constantly varying visions of the *new medicine* are being presented to us. However, we dare not regard them simply as visions, for there is something realistic in all of them, and in all of them appears the most essential feature of any possible successful plan of reconstruction in the practice of medicine—the co-ordination of its diversified faculties.

The considerable expansion of the United States Public Health Service and its co-operation with, or control of, the public health service of the various states, together with the rapidly increasing favorable attitude of the people toward public health measures, lends much weight to the predictions of the officers of these organizations that the future of medicine will lie within their jurisdiction.

On the other hand the rapidly increasing patronage of hospitals and the favorable reception of the rural hospital idea, naturally inclines those who are most closely associated with these institutions to see in their better equipment for diagnosis and treatment, and the more careful organization of their staffs, the feature which will play the most prominent part in the medicine of the future.

But there is still another source of visions, those who are not intimately associated with the public health service nor with the hospitals. They see in group organization the ultimate solution of the problem which will soon—if it does not now—confront us.

It would require a genius indeed to devise a plan of reconstruction that would require no modification, but all of the visions so far presented seem to be impractical under present conditions. Those

who foresee the federal or state control of medicine have certainly good grounds for argument, but to those now outside of the Public Health Service there seems good reason to fear its results. The most serious objection, and the condition which most threatens the successful issue of such a plan, is the inadequate compensation for the services required. In the government service, compensation is regulated by rank, and rank is regulated by age of service or political influence. Reward for efficiency is problematical, and yet efficiency is the dependable asset in the successful practice of medicine.

In private practice efficiency brings its reward in increased business and increased fees. It is the recognition of this fact that has given an impetus to the so-called "group medicine." But, except in a few instances, group medicine has not proven to be practical. A considerable capital is required to carry such an organization over its developmental period, for a large volume of business must be controlled if each individual of the group is to be properly compensated. Many such organizations have disintegrated because of an unsatisfactory financial basis for operation.

The well equipped hospital, the hospital whose motto is efficiency, possibly the standardized hospital, is essential in the successful practice of medicine. It is essential to the ultimate success of the federal or state controlled medicine. It is fully as essential to the successful issue of group medicine.

The hospital idea is being rapidly popularized, and in a short time the private hospitals will be replaced by county, municipal and community hospitals. With a well equipped hospital in every community the basic principle of group medicine may be carried out, even in the smaller towns.

Notice to Secretaries

At the last meeting of the Council it was decided that those medical officers who were discharged from the service prior to April first should pay dues for the current year. All those who were still

in service on April first should have their dues to the State Society remitted for the current year.

A recent number of the Ottawa World contains an article (marked advertisement) which attempts to ridicule the through and through irrigation of the colon, now sometimes employed in the treatment of infectious colitis and other diseases of the colon. In fact, the whole trend of the article seems to be to belittle the knowledge of the medical profession and make light of its efforts to cure disease.

All this might pass without notice, but in an appendix to the article the author attempts to enlighten the public on the subject of pyorrhea and gives out the impression that this disease is always a result of taking mercury; and incidentally mentions a once popular notion of the relation of mercury to syphilis. He says: "Mercury may remain dormant in the system for years, awaiting the development of an acid state, before it starts up a disease of teeth and bone. *This is the nemesis that our modern medical science denominates syphilis.*"

This article would, no doubt, receive no more attention than it deserves did it not appear under a column headed "Health Hints" and with the signature of a doctor. But that is sufficient to make a good many people accept the statements as true. At this time when every effort is being made, and large sums of money are being spent by the government, the state and by nearly every city, to eradicate venereal disease, it is unfortunate that there are still papers in the state willing to lend their space to an opposition propaganda.

This seems to be the proper season for the discussion of what constitutes an intoxicating beverage. At least there have been a good many articles on the subject recently published.

After some one has defined "intoxication," or determined the degree of alcoholic effect that constitutes intoxication, it

will be interesting to observe the method by which the minimum alcoholic strength of an alcoholic beverage is determined.

A commission appointed by the British Government to determine this point observed the alcoholic content of the blood and by combining this with the amount ingested and the effects upon the individual found that in mild intoxication the alcoholic content of the blood was 0.15 per cent, and to produce this in a man weighing 140 pounds required the injection of about six ounces of whiskey at proof, or four pints of beer of 4 per cent strength.

Professor Sherwin, of Fordham University, has an article in the New York Medical Journal, May 31, in which he estimates the alcoholic strength required for an intoxicating beverage. In New York it is held that "a beverage containing so small a percentage of alcohol that the human stomach cannot obtain sufficient of the liquor to produce that effect" is not an intoxicating liquor. From numerous experiments he concludes that "forty grams of alcohol is about the maximum dose that may be injected by the normal person without producing any symptoms of what is commonly known as intoxication." Estimating the capacity of the normal stomach at one and a half liters, and diluting forty grams of absolute alcohol with water to make one and a half liters, he gets a solution containing 2.26 per cent alcohol by weight, or 3.35 per cent by volume.

It is generally conceded that there are other elements contained in many alcoholic beverages which have something in the way of an intoxicating effect. There is also much variability in the effects of alcohol upon different individuals and upon the same individual at different times.

If some scientific basis is determined by which the per cent of alcohol required to constitute an intoxicating beverage can be estimated with a fair degree of accuracy, it will apply only in relation to normal individuals under normal conditions.

In some courts personal evidence as to the intoxicating effects of a beverage is

admitted, and if a number of people testify that they have been intoxicated by drinking that beverage, it is declared intoxicating. This is a fairly safe procedure where the evidence can be secured, but establishes no standard. It must also be considered that such testimony is quite likely to be unreliable.

—————R—————

In the report of the Judicial Council of the A.M.A. we find the following: "The Judicial Council has been informed that actuarial statistics bear out the following statement, namely: That on the average of 100 individuals entering on a business career at the age of 25, when these have reached the age of 65 years, five of the 100 will be in comfortable circumstances financially; six will be self supporting; fifty-three will be receiving financial assistance of some form; the balance will be dead."

—————R—————

Excerpts—By The Prodigal

Is it true?—That a doctor is born and not made? This is an adage in the profession. There is cause for the statement. There can be no suggestion to the human mind without a cause.

Experience proves that there is medical acumen in some men and families the same as there is a mechanical and musical talent in other men and families.

A young man may have a literary and medical college degree and knowledge, and not have wisdom to use it from lack of natural ability and be a poor doctor. Whereas a literary and medical mediocre in knowledge may be successful in practice. Neither one will make a safe practitioner of medicine. But when the scholastic and medical knowledge and acumen are united in one and the same person—the knowledge and wisdom—the product will be an ideal physician.

It is said that the way to improve the human race is to begin with the grandparents. That statement is an enigma. The way to improve the medical profession is to eliminate the unfit in their non-age—in the student age.

An entrance examination to the medical college by an examiner, who is fit to be a medical examiner, can soon determine the capabilities of a prospective medical student as to whether nature as well as art has designed him for a doctor. For example: The proposed medic should have some reserve; something behind the surface to call on in time of an emergency. At any rate he should not be like the student who answered that "A tablespoonful of croton oil is a dose," and at the expiration of the hour said, "I want to correct my answer, that a tablespoonful of croton oil is a dose." The teacher told him that this patient had been dead forty minutes. A quick explosive or ignorant answer given by a prospective medical student to questions of vital import, marks that student unsafe and he should be put on probation as a probable eliminant, at least.

Again—the prospective surgeon should not be found wanting in poise and reserve, but in addition he should show some adaptability to mechanics. He should be able also to take hold of a knife and surgical instruments more or less dextrously from the beginning. Some surgeons who are well prepared theoretically make the on-lookers and helpers to a surgical operation he is performing restless and nervous by the way he does his work and handles the instruments. Such a surgeon should have been put on the student waiting list and tried out a little before he was O. K.'d, and the chances are he would be set to pounding rock.

Doctor, are you satisfied with yourself? Are you satisfied with your practice? with your success? with your standing in the community in which you live? with your standing professionally? with your professional attainments? your literary proficiency? your financial condition? your vacation? Are you satisfied with all of these? If you are satisfied, you deserve pity. You have gotten your growth. You have attained your ideal. Progress for you from now on has ceased. To be satisfied is to be relieved of all doubt or uncertainty.

Not that you should be dissatisfied with one or all of your attainments or conditions, but you should be unsatisfied, pleased with what you have, and make your present attainments and qualifications and standing stepping stones for a higher, better and more useful professional life.

For a doctor to stop progressing means professional retrogression, decay and death. To be satisfied means that all doubts have been cleared away; all uncertainties have become established facts. There is nothing more to do but to sit tight and float serenely down the river of time and be dumped over the Niagara an inert mass to be returned to mother earth, that she may try her hand again to fashion a more comely, shapely and useful entity.

* * *

Swat the fly. But it is better to entrap and burn him. Also remove the food on which he feeds.

* * *

"Yes," said one negro, "I'se gwine ter git me a eucalyptus."

"A what?" queried the other negro.

"Eucalyptis—dat's a musical instrument, you fool nigger."

"Go on, nigger! Yo' can't kid me—dat's one ob de books ob de Bible."

* * *

Why is the funny bone?

Because it associates with the humerus.

* * *

Doctor: Avoid too-tonic remedies.

Get in touch with the mental temperament of your patient.

Take the measure of yourself. Get up the required professional momentum that you can maintain, keep it up and you will live a useful professional man's life.

The progress of civilization depends upon the accumulation of wealth, therefore allow a little to oxidize upon you while you are in the productive age.

* * *

The doctor who treats the physical man only treats the lesser half of man.

* * *

Dr. Ewing tells of an Irishman brought into the hospital badly shot up. "What are

you?" demanded the surgeon. "Sure an' Oi'm half Irish," confided Pat. "Well, what's the other half?" "Holes and band-ages," muttered Pat as he went out under the ether.

* * *

Do not consider yourself a moderate smoker because you smoke but one cigar at a time.

* * *

Remember that "human events are governed by fixed laws. Each generation demonstrates some events to be regular and unpredictable."

* * *

Of the 124 cases of influenza in Sing Sing prison, New York, in 1918-19, all recovered.

* * *

The latest in telephone use is a wireless phone in the man's hat so he can be managed from home, by wifey.

* * *

The latest in women's dresses is a band around the waist to hold up her tubular one-legged trowsers.

—————R—————

Fables for the Kansas Doctor

By RENNIG ADE

(No Relation to George)

Once upon a time there was an old doctor who lived in a small town. He was not very clean in his appearance and habits and was therefore awful good on fevers. He was an allopath, or, as he called himself, a regular, and was very intolerant of all other creeds. He was an old army surgeon and often spoke of the operations he did during the war. Amputations were his strong suit and quite a number of his cases recovered. He loved the atmosphere of laudable pus, and calomel, and the rattle of loose teeth was sweet music to his ears.

When the war was over, and after arranging for his pension, he settled down in the aforesaid small town to practice medicine, which at that time consisted principally of child-bed fever and typhomalaria. He was very jealous of his clientele and resented the intrusion of other practitioners in his field.

One day there blew in a recent graduate with a diploma, a stethoscope, and a fever thermometer which fastened to his outside coat pocket with a medium sized didy-pin. He had the degrees of M.D., A.B. and B.S. with the accent on the latter. Se settled above the drug store and was introduced to everybody by the druggist, who didn't like Old Doc because he couldn't write prescriptions. The new doctor wanted to be ethical so he called on Old Doc and outlined his plans. He magnanimously offered to let Old Doc live for a time, at least, and promised to throw him his anesthetics. He told the Rexall cadet at the drug store about the operations he had been doing at the hospital where he had served his internship. This was later repeated by the clerk around town until the young doctor got quite a reputation as a surgeon, without the loss of a man. The people also said he was not much good on sickness and fevers.

To show the perversity of the Fates that rough hew our ends, ten years later Old Doc was tearing around in an eight-cylinder buzz wagon, putting on a clean celluloid collar every other day and still making a good living. The young doctor was a member of the school board, had a large fever practice, shipped one or two good surgical cases to Kansas City every month and was gradually forging ahead in his noble life work.

Moral: You can't always tell whether the letters attached to a doctor's name are meant to be honorary or descriptive.

—————R—————

BOOKS.

The Surgical Clinics of Chicago

Volume III, Number 2 (April, 1919). Octavo of 242 pages, 62 illustrations. Philadelphia and London: W. B. Saunders Company. 1919. Published bi-monthly. Price per year, paper, \$10; cloth, \$14.

The April number of the Surgical Clinics of Chicago is of extremely practical value, most all of the cases presented being such as every practitioner is likely to meet. In one of his clinics Dr. Willys Andrews illustrates a method of drilling the ends of the bones in ununited frac-

tures, a method adopted many years ago by Dr. Brainard, one time surgeon and president of Rush Medical College. In his clinic on harelip and cleft palate, Dr. A. J. Ochsner shows a method of relieving the tension on the lip sutures by silk strands attached to adhesive plaster on forehead and cheeks. Dr. Arthur Dean Bevan has a very interesting lecture on appendicitis, in which he makes a very definite statement in regard to chronic appendicitis in persons who have never had an acute attack. He says: "I do not recognize such a condition as chronic appendicitis which has never given rise to any acute symptoms. Almost invariably these are cases of colitis, constipation, associated often with the taking of cathartics, and clean up under medical management."

Eisendrath shows a fractured patella and the operative treatment. He believes in early operation in these cases.

Practical Medicine Series, 1919

General Medicine, edited by Frank Billings, M.S., M.D., head of the medical department and dean of the faculty of Rush Medical College; assisted by Nurrell O. Raulston, A.B., M.D., and Bernard Fantus, M.S., M.D. One of a series of eight, issued at about monthly intervals, beginning in May, and covering the entire field of medicine and surgery. Each volume being complete on the subject of which it treats for the year prior to its publication. Published by the Year Book Publishers, 304 South Dearborn St., Chicago. Price of this volume, \$2.50; series, \$19.

This is not a general text book on medicine, but is intended to present all that has been added to our knowledge of the various subjects during the year preceding. As such it is a valuable addition to any medical library, but is particularly appropriate for the use of the busy practitioner.

The Blind: Their Condition and the Work Being Done for Them in the United States

By Harry Best, Ph.D., author of "The Deaf; Their Position in Society and the Provisions for Their Education in the United States." Published by the Macmillan Company, New York City.

Few of us have much information about the subject the author discusses. We know there are blind people and feel sorry for them, but have little conception of the number of blind or the difficulties they encounter. It is only in recent years that

any systematic effort has been made toward the prevention of blindness in infancy. The author discusses in regular order, the general condition of the blind, blindness and its possible prevention, provisions for the education of blind children, intellectual provisions for the adult blind, material provisions for the blind, organizations interested in the blind, and conclusions with respect to the work of the blind.

In his conclusions the author states that no more than seven per cent of the entire number of blind over ten years of age are able to maintain themselves, and of the entire number over twenty years of age only a little more than one-eighth are self-supporting.

Administration of Arsphenamine

The U. S. Public Health Service has issued a circular concerning the dilution and the rate of administration of arsphenamine solutions. A study as to the cause of the disagreeable results following the use of the various preparations of arsphenamine has indicated that most disagreeable results are not inherent in the preparations but are produced through faulty steps in the administration of the remedy, chiefly from the use of a too concentrated solution and by too rapid administration. (Jour. A. M. A., May 10, 1919, p. 1372.)

The Government has on hand a surplus of 140,433,642 pounds, 4,681 car loads, of canned meat—bacon, roast beef, corned beef and corned beef hash—for which bids are being asked from the state and municipal charitable institutions.

"Neurocirculatory asthenia is an abnormal state occurring in individuals whose physical substratum is wanting in that something which makes for a perfectly coordinated organism."—(Barach). Since the war this condition is described as N. C. A. and includes those cases termed by Da Costa the "irritable heart of the soldier."

SOCIETY NOTES

PRATT COUNTY SOCIETY

At a meeting of the Pratt County Medical Society, May 5, the following resolution was adopted:

"Whereas, some newspapers are in the habit of publishing the names of doctors in connection with reports of medical and surgical cases, and .

"Whereas, such reports are embarrassing to the ethical physician and do not serve the best interests of the public, therefore be it

"Resolved, by the Pratt County Medical Society, that the newspapers of Pratt County be requested to not publish the names of physicians in connection with any medical or surgical cases."

JOHNSON COUNTY SOCIETY

The monthly meeting of the Johnson County Medical Society was held in Olathe on Monday, February 17, and was called to order by the president, Dr. Charles Lester. The following members were present: Drs. Charles Lester, R. E. Eagan, C. C. Thomas, J. H. Stough, Thos. S. Greer, R. M. Moor, F. F. Greene, Jennie T. Orr.

Dr. McCallum of Kansas City, Mo., read a very interesting and instructive paper on Renal and Vesical Calculi, emphasizing the importance of making a correct diagnosis, using not only the X-rays but having the same checked up by the urologist. This point was illustrated by numerous specimens of calculi and stereopticon views.

The following officers were elected for the year: President, R. E. Eagan, Spring Hill; vice president, F. F. Greene, Olathe; secretary-treasurer, R. M. Moor, Olathe.

A committee was appointed to draft resolutions on the death of Dr. John R. Sloan and made the following report:

Whereas, Dr. John R. Sloan, of Stanley, Kansas, has been removed from our midst, and whereas the wife and son have lost a devoted husband and father, the community in which he lived a faithful physician and an honest citizen, and

Whereas, Dr. Sloan was a true and dependable member of this Society and devoted some forty years of his life to the practice of his profession,

Therefore be it resolved by the Johnson County Medical Society that in the death of Dr. Sloan it has lost one of the most loyal members and that our society extend to Mrs. Sloan and son our heartfelt sympathy, and that a copy of these resolutions be entered on the minutes of the society and a copy sent to his family.

THOMAS S. GREER

O. C. THOMAS

F. F. GREENE

Committee.

HARVEY COUNTY MEDICAL SOCIETY

At the June meeting of the Harvey County Medical Society on Monday evening, the physicians enjoyed hearing of the work done by three of the members in their respective sections of the army service. These were Capt. M. C. Martin, Capt. R. C. Hartman and Capt. H. M. Glover. In addition to this a paper was read by Dr. Frank L. Abbey on radium and its use.

The officers of the Society for 1919 are: Dr. A. E. Smolt, President; Dr. R. S. Haury, vice-president; Dr. Frank L. Abbey, secretary-treasurer.

FRANK L. ABBEY, Secretary.

SUMNER COUNTY SOCIETY

The Sumner County Medical Society met in Wellington on the 27th. Dr. M. W. Axtell presided. He reminded us that the period of the past few months has been that of the world's greatest event—the greatest war in all time ended in the greatest national and political upheaval recorded in all history. At the same time raged what was probably the greatest epidemic in all time. He urged more frequent meetings and a closer friendship with more unity of effort by society members. The applications of Eugene Pile, Portland; J. H. Stallard, Geuda Springs; Frank Kerr, Mayfield, and R. H. Downing, Wellington, were received and acted favor-

ably upon. The secretary stated that there were now but three regular practitioners in the county who were not members of the society.

Dr. E. T. Erickson, of Caldwell, has returned from a sojourn in a Michigan sanitarium, recuperating from a heart lesion acquired last October from the "flu."

Dr. D. E. Kisecker was made health officer of Caldwell on his return from twenty-two months service in the M. C. U. S. A.

Dr. C. M. Zink, after serving in the army for twenty-two months, has located at Clinton, Indiana.

A new hospital has been erected at Oxford.

T. H. JAMIESON, Secretary.

SEVENTH DISTRICT SOCIETY

The Medical Society of the Seventh District met in Hutchinson on April 24. An all day and evening session was held. The following program was provided:

9:00 A.M.—Surgical clinic, Dr. J. E. Foltz, Hutchinson.

10:00 A.M.—Medical clinic, Dr. C. Klippel, Hutchinson.

11:00 A.M.—Medical and surgical clinic, Dr. E. E. Morrison, Great Bend.

11:30 A.M.—Surgical clinic, Dr. T. A. Jones, Hutchinson.

Annual business meeting and payment of dues.

"Endocrinology," Dr. J. T. Scott, Saint John.

"Influenza," Dr. D. B. Buhler, Pretty Prairie.

Case Reports—Reports limited to five minutes and one case from each member present. Discussion limited to three minutes for each member present.

"Some Experiences on the Western Front," Capt. W. N. Mundell, Hutchinson.

"The Management and Treatment of Syphilis," Dr. Nelse F. Ockerblad, Kansas City, Mo.

"Purulent Ulcer of the Cornea," Dr. J. H. Schrant, Hutchinson.

"Theory and Practice of Non-Specific

Therapy," Dr. Wilson A. Myers, Kansas City, Mo.

"Factors for Safety in Prostatic Surgery," Dr. R. Y. Jones, Hutchinson.

W. F. SCHOOR, Secretary.

RICE COUNTY MEDICAL SOCIETY

The Society met at Sterling in the hospital, June 7, with nine members present. Dr. Maggie L. McCrea gave a talk on Child Hygiene in Our Schools. Dr. H. R. Ross gave a paper on Hospital Standardization and What It Means for the Hospitals of Rice County.

Capt. Marion Trueheart is recovering from an operation at the hospital at Ft. Riley.

Lieut. H. P. Knowles has recently returned home from work in France.

Word comes that Lieut. L. S. Fisher, formerly of Raymond, has located in Kansas City, Kansas.

Dr. Muir of Alden took his family by auto and is attending the A.M.A. at Atlantic City and will visit points of interest before their return.

Dr. Wallace of Chase is in Chicago attending clinics.

Dr. Bush of Geneseo is away on a short vacation.

H. R. ROSS, Secretary.

State Nurses' Association

The eighth annual meeting of the Kansas State Nurses' Association was held in Hutchinson, May 9 and 10. There were seventy-five nurses in attendance, out of a membership of three hundred. The morning of the first day was devoted to the formal opening exercises and the transaction of business. The afternoon was given over to the Red Cross and Public Health Section. Major Bahrenburg, of St. Louis, gave an address on "The Control and Combating of Venereal Diseases." He urged the nurses to take up the fight for clinics and dispensaries. He showed why the demand for federal, state and county appropriations to help stamp out the diseases is both legitimate and obligatory.

Friday evening Mrs. Ethel Parsons, di-

rector of Public Health Nurses, gave an interesting address. The round tables and sectional meetings of the superintendents of training schools, Public Health nurses and private duty nurses, were well attended and proved to be very profitable.

On Saturday afternoon the following papers were read and discussed: "Private Duty Nurses Fifteen Years Ago," by Ethel Dilts, R.N., Newton; "Private Duty Nurses of Today," Bertha Bumgartner, Halstead; "Function of the Training School in Elevating the Standard of Nursing," Dena Gronewald, McPherson.

On Saturday evening a memorial service was held, Mrs. Alma O'Keef presiding, in honor of Jane Denalo and twenty of our deceased Kansas nurses. Miss Lydia Anderson offered the tribute to nurses who made the supreme sacrifice. Lieut. Leo T. Gibbons, of Dodge City, delivered the memorial address. The following resolutions were adopted:

"Whereas, Miss Alma Murphy, Miss Eva McElwain, Miss Ella Achrader, Mrs. Margaret Bogan McAuliffa, Miss Hazel Everett, Miss Carlisle Everett, Miss Myrtle Swanson, Miss Mildred Kerr, Mrs. David Curry Mumford, Miss Julia M. Tyler, Miss Elizabeth Dickson, Miss Tracy Verhague, Miss Jessie Dicks, Miss Winnie Sawyer, Miss Mary Lamb, Miss Alberta Beighner, Mrs. Vera Scott Simmon, Mrs. Maud Marie Wilson, Miss Osborn, Miss Ella Bair, Miss Grace Black, Miss Inez Hopkins, registered nurses of Kansas, in the discharge of their professional duties have made the supreme sacrifice in the service of their country,

"Resolved, that the Kansas State Nurses' Association go on record as appreciating their spirit of earnest and untiring service in the discharge of their duties, and that their example lead us to renewed efforts in making practical the ideals of our profession.

"Resolved, that the sympathy of the sister nurses be extended to the families of the nurses and that a copy of these resolutions be incorporated in the minutes of the K.S.N.A."

The following officers were elected: W. Pearl Martin, Topeka, president; Dena Gronewald, McPherson, vice president; Mrs. W. R. Saylor, Hutchinson, secretary; Miss Kate Williams, Hutchinson, treasurer.

One of the most important transactions of this meeting was the adoption of a list of maximum fees for nurses, a copy of which with the resolutions concerning it appears below.

NURSING RATES (TO BE USED AS A GUIDE)	
General cases, per week.....	\$30.00
General cases, less than one week,	
per day	5.00
Obstetrical cases (delivery included), per week.....	35.00
Delivery only	5.00
Contagious cases, per week.....	35.00
Small pox, per week.....	50.00
Alcoholics, drug fiends, neurasthenics and insane, per day.....	5.00
Operations only	5.00
Clergymen, physicians and nurses, per week	20.00
Cleansing, medicinal or ice baths, each	1.00
Relief work, each twelve hours.....	5.00
Hourly nursing—first hour.....	1.00
Each additional hour50
Maximum charges, irrespective of number or kind of cases in one home, per week	50.00
Traveling expenses to be paid by the employer.	

The R. N. should be relieved for six consecutive hours' sleep and two additional hours' recreation out of each twenty-four hours.

NOTE.—This price list is offered with a view to informing physicians of the legitimate fees charged by Registered Nurses in the State of Kansas, and to protect the public from excess charges from all classes of nurses.

Be it resolved, that this Kansas State Association of Graduate Nurses stand in unison on the disapproval of profiteering in their profession, and go on record in stating: that a nurse's charge exceeding the rates given for publication as a guide be considered unethical, and said nurse be

reprimanded by the Board of Directors of this Association.

—————R—————

"Procaine," a New Free Booklet Which May Be Had for the Asking

"Procaine for Local Anesthesia in Surgery, the Specialties, and Operative Dentistry," is the title of a new booklet by Dr. F. H. McMechan, editor of the American Yearbook of Anesthesia and Analgesia. It is an editorial abstract of a series of articles on local anesthesia prepared by Doctor McMechan, and presents in simple, boiled down, yet detailed style the advantages of Procaine over other local anesthetics; the various solutions and combinations used and how to prepare them from marketed products; indications and contraindications; and the technic for its use in spinal, sacral, venous, ophthalmic, rhinolaryngologic, and dental anesthesia. A number of excellent illustrations add to its value.

This booklet may be had free by any physician, hospital superintendent, surgeon or dentist sending his request to The Abbott Laboratories, 4757 Ravenswood Ave., Chicago, Ill. Everyone who secures it will find it distinctly worth while.

The Abbott Laboratories are making Procaine under license from the Federal Trade Commission and supplying it in standard market packages under the well known guarantee of purity and accuracy.

—————R—————

Phosphorus Metabolism

The more recent investigations on digestion and absorption all point to the probability that phosphorus from the digestive tract reaches the general circulation only in the form of inorganic phosphates and that all organic phosphorus compounds are synthesized in the body cells. This is in support of the conclusion of the Council on Pharmacy and Chemistry in forming an estimate of the therapeutic potency ascribed to preparations of organically bound phosphorus, such as lecithin, glycerophosphates, phytin, macleic acid and phosphoproteins. All the newer researches give no indication that the body is dependent

on a ready made supply of phosphatid (phosphorized fat) in the diet to maintain normal nutrition. (Jour. A.M.A., May 3, 1919, p. 1294.)

—————R—————

F. M. Bell, head of Armour & Company's pharmaceutical department, sailed recently for Europe where he will study business conditions and get an inside viewpoint of the general pharmaceutical activities in foreign countries. Mr. Bell's visit, which will last approximately two months, will include trips through England, France and Italy.

Armour & Company's line of pharmaceutical goods, which is well known in medical circles, has been under the direction of Mr. Bell for many years.

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Typhoid fever, which has a record of disabling 10 per cent of the personnel of armies in campaigns, is no longer a disease which needs to be reckoned with by our military authorities. By the simple expedient of three hypodermic injections into the arm of each soldier the menace of this disease has been entirely eliminated. It is obvious that if every person outside the army could be induced to submit to the same treatment the disease would just as quickly disappear from civil life.

There is just one measure—and that an extremely simple one—by which the menace of typhoid fever may be entirely removed, and that is prophylactic vaccination.

It was in 1912, after careful study of the subject, that the Mulford laboratories first advocated the use of the Triple Typhoid Bacterin or Vaccine (Typhoid, Paratyphoid "A" and Paratyphoid "B") now commonly known as TAB. The use of Triple Typhoid Vaccine in the armies has since become universal.

The Mulford Laboratories have also made available "sensitized" vaccine or "serobacterin," in which the suspended bacilli have been acted upon by their own immune serum. The chief advantage of the sensitized vaccines or serobacterins lies

in the fact that they bring about the immune state more rapidly than do the plain or unsensitized bacterins—and this is an extremely important point in civil communities in the midst of epidemics—and, as a rule, the local and general reactions following their use are milder than those following the use of unsensitized bacterins. When serobacterins are used it is therefore possible to administer twice the number of killed bacteria used in the unsensitized bacterins.

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Treatment of Pneumonia

The following experiments were tried out in the hospital at Camp Wheeler, Ga. The method of management was as follows, from October 5 to November 24, 1918. Fifty days was the so-called open air or open ward treatment. It can be thus summarized:

1. All windows and doors in the wards were to be kept open day and night. Rain, cold winds and damp night air are no contradiction to the order.

2. No screens or blankets were to be hung up at the windows or placed before the doors to prevent the free circulation of the air in the wards.

3. Soldiers in the wards were encouraged to keep their heads close to the windows and lie so that the cold air sweeping in from the outside could be better breathed in. If a soldier complained of a cold draft of air on his head, he was told it was good for him; that the fresh air would make him well.

4. No cotton jackets or chest protectors were to be used. The patients were to be supplied with blankets.

5. Ward fires were to be allowed to go out at night. On cold, damp days the wards were always cold and chilly, because all windows and doors were open.

Under the open ward or open air treatment (Group 1) 966 patients with acute pneumonia were cared for between October 5 and November 24, 1918, with 135 deaths, a mortality of 13.9 per cent. November 24, while the epidemic was at its

height, a radical change in treatment was made, as follows:

1. All windows and doors in the wards were ordered closed and patients guarded in every way possible from drafts of cold air, chilling and exposure.

2. All sick soldiers with pneumonia on outside porches were ordered moved into wards and cared for indoors where they were warm and comfortable.

3. Every soldier with pneumonia was provided with a cotton jacket to keep the chest warm and to protect it from drafts and currents of cold air.

4. Ward surgeons, nurses and corps boys were instructed to handle and care for their patients so as to avoid at all costs, chilling. The bed clothing was to be tucked in. The arms to be kept under the bed covers. Plenty of blankets were to be used on cold nights, etc.

5. Fires in wards were ordered kept going day and night. Wards were to be kept free from a feeling of chilliness in the air. This could not always be done on cold days.

6. Special nurses were provided for the desperately sick.

7. Bathing was discouraged except for purposes of cleanliness, and then only when wards were warm.

Attending medical officers were cautioned to avoid prolonged examinations and protect the patients well from chilling while examinations were being made.

(Group Two.) Under the closed ward treatment as outlined in the foregoing, 435 patients with active pneumonia were cared for between November 24, 1918, and February 1, 1919, with fourteen deaths, a mortality of 3.2 per cent.—*Journal American Medical Association*.

With the open air treatment or exposure fourteen out of one hundred died—about one of every seven. With the rational, sensible, humane care about three died of each one hundred, or one out of every thirty-two. Of the 124 cases of influenza in Sing Sing prison, New York, there was not one death. How fortunate the 966 sick soldiers would have been if

they had all been in Sing Sing, and received rational treatment and intelligent care instead of being deliberately and ignorantly exposed to the elements until death ended the sufferings of 135 soldiers, and this in enlightened America! Will the medical profession stand for it?

DR. J. E. MINNEY,
2273 W. 20th St., Los Angeles, Cal.

—R—

New and Nonofficial Remedies

Atreol.—An aqueous solution containing as its principal constituent the ammonium salts of a mixture of organic acids containing nitrogen in the sulphonic radical which results from the action of sulphuric acid on certain petroleum distillates. Atreol is applied locally for promoting the absorption of swellings and effusions in contusions following fractures, etc. It is claimed to be useful in dermatologic and gynecologic practice. It may be used in aqueous solutions, ointments and suppositories. The Atlantic Refining Co., Philadelphia, Pa. (Jour. A.M.A., May 17, 1919, p. 1463.)

Gilliland's Concentrated and Refined Diphtheria Antitoxin.—Marketed in ampules containing 1,000, 5,000 and 10,000 units each. For a description of Diphtheria Antitoxin, Concentrated, see New and Nonofficial Remedies, 1919, p. 280. Gilliland Laboratories, Ambler, Pa.

Gilliland's Concentrated and Refined Tetanus Antitoxin.—Marketed in ampules containing 1,500, 3,000 and 5,000 units each. For a description of Tetanus Antitoxin, Concentrated, see New and Nonofficial Remedies, 1919, p. 266. Gilliland Laboratories, Ambler, Pa.

Gilliland's Antipneumococcus Serum, Type I.—Marketed in vials containing 100 c.c.; also in double-ended vials containing 50 c.c. each, with a gravity injection apparatus for intravenous injection. For a description of Antipneumococcus Serum, see New and Nonofficial Remedies, 1919, p. 271. Gilliland Laboratories, Ambler, Pa.

Gilliland's Small Pox Vaccine.—Marketed in sealed capillary tubes in packages containing two tubes each. For a descrip-

tion of Vaccine Virus, see New and Nonofficial Remedies, 1919, p. 274. Gilliland Laboratories, Ambler, Pa.

Gilliland's Original Tuberculin, "O. T."—Marketed in 3 c.c. vials. For a description of Old Tuberculin, see New and Nonofficial Remedies, 1919, p. 277. Gilliland Laboratories, Ambler, Pa. (Jour. A.M.A., May 17, 1919, p. 1463.)

Barbital-Abbott Tablets, 5 grains.—Each tablet contains 5 grain of barbital-Abbott (see New and Nonofficial Remedies, 1919, p. 82). The Abbott Laboratories, Chicago.

Procaine Hypodermic Tablets, $\frac{3}{4}$ grain.—Each tablet contains $\frac{3}{4}$ grain of procaine-Abbott (see New and Nonofficial Remedies, 1919, p. 30). The Abbott Laboratories, Chicago.

Procaine-Adrenalin Hypodermic Tablets.—Each tablet contains procaine-Abbott $\frac{1}{3}$ grain and adrenalin 1-2500 grain (see New and Nonofficial Remedies, 1919, p. 30). The Abbott Laboratories, Chicago. (Journal A.M.A., May 17, 1919, p. 1463.)

Protargentum-Squibb.—A compound of gelatin and silver containing approximately 8 per cent of silver in organic combination. It has the actions and uses of silver preparations of the protargol type (see New and Nonofficial Remedies, 1919, p. 307). Protargentum-Squibb is used in 0.25 to 5 per cent aqueous solutions, prepared freshly as required. E. R. Squibb & Sons, New York. (Journal A.M.A., May 24, 1919, p. 1543.)

Antimeningococcic Serum, Combined Type (Gilliland).—Marketed in 15 c.c. and 30 c.c. ampules and in 15 c.c. and 30 c.c. cylinders with attachments for spinal administration. For a description of Antimeningococcus Serum, see New and Nonofficial Remedies, 1919, p. 270. Gilliland Laboratories, Ambler, Pa. (Jour. A.M.A., May 24, 1919, p. 1615.)

—R—

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man of the central committee of the organization:

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"It has been decided to make this appeal in the autumn, in a period of two weeks culminating on the eleventh of November, the anniversary of the signing of the armistice—a season when the American people may properly give manifestation, through contributions to their Red Cross, of their thankfulness for deliverance from added horrors of war which have fallen upon nations less fortunate.

"At present the American Red Cross is bringing to a close its activities in the countries of Western Europe, and with the withdrawal of American troops from the war zone its work for the army abroad will end automatically. Disease and suffering of the most heartrending character, however, are calling for relief in other fields. The new international organization of Red Cross societies is preparing to deal with relief and health problems throughout the world in future years, but there are immediate emergencies which require the aid of the agencies already established. Foremost among these agencies is the American Red Cross. At present emergencies are being met with all the resources available, but it is apparent that the imperative calls for assistance for the next year or more will make additional funds necessary.

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— I; —

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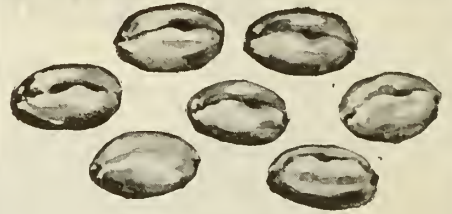
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Empyema.

W. P. CALLAHAN, M.D., Wichita, Kan.

Read at the Annual Meeting of the Kansas Medical Society held at Ottawa, Kansas, May 7 and 8, 1919.

During the last two years empyema has been one of the important surgical conditions that has come up for consideration, due to the frequency of its occurrence, and its high mortality. It has attracted considerable attention and the interest manifested in it has been enhanced by the widely different results that have been reported. The rapidly fatal outcome following early operation on a number of patients showed us that we were apparently dealing with a condition somewhat different from what we had ordinarily considered empyema at home and that therefore different treatment was required. Upon investigating more carefully it was found that we were confronted with two different conditions, one an empyema following the usual lobar pneumonia, and the other secondary pneumonia.

This paper is based on the study of 76 cases that have come to operation in the past seven months period, from October 1 to May 1, 1919, of which seventy cases were secondary infection, following the recent influenza epidemic, and the other six following measles.

Types of Empyema. I believe all empyema should be classified according to the bacteriological findings. In this series the pneumococcus was found in twenty-three, hemolytic streptococcus in twenty-two, non-hemolytic streptococcus in three, staphylococcus hemo in one, the other cases were not typed, or there was no positive

report, the staphylococcus was due to contamination.

In the diagnosis of empyema in this series of cases, a condition was designated as empyema which showed an acute non-tubercular collection of exudate in the pleural cavity. The cases range in character from those with slightly turbid fluid, microscopically found to contain pus cells and organisms in smear or culture, to those with thick yellowish gray pus. There seems to be four definite stages in the pathology of empyema: fibrinous, sero-fibrinous, sero-fibrino-purulent and purulent. The usual early finding for a variable period of about a week is the sero-fibrino-purulent exudate. At autopsy it was a frequent finding to have a sero-fibrino-purulent exudate in one pleural cavity and a fibrinous or sero-fibrinous exudate in the other. It is important to recognize further that, while the course is usually progressive through the various stages toward the end or purulent stage, the fibrinous or sero-fibrinous pleuritis may proceed no further than those stages, the case not being a true empyema. These first two stages are frequently found in cases of pneumonia and great care should be exercised that the cases of sero-fibrinous exudate should not be thought cases of empyema and operated on. Neither should the possibility of a fluid being purulent be lost sight of.

The most common primary empyema, primary so far as the lung condition is concerned, is found following measles, of which in this series we had six cases. The usual early signs, as well as the persisting physical signs, were those of fluid rather

than of consolidation. At autopsy a broncho-pneumonia, however, was found present in one case, it being impossible to state with any degree of assurance whether the empyema or the pneumonia was the older process. The stage of consolidation and the degree of organization of the exudate are usually very definite. However, as to degree we may place the empyema as the primary condition. Further evidence of the priority of this empyema was obtained from the distribution of pneumonia, the consolidation appearing at the periphery as a shell, apparently secondary to an overlying empyema, by an extension infiltration, again completely encircling an interlobar empyema like a very thick orange skin.

The absorption from the fulminant type of empyema is a large element in the seriousness of empyema, complicated or uncomplicated by pneumonia. It is demonstrated in cases of empyema known to be uncomplicated by pneumonia as often the septic condition of the patient is extreme. It cannot, it seems, be fairly said that the serious side of the pneumonia complicated by empyema is due to the pneumonia more than to the empyema. Indeed, the mortality of uncomplicated primary empyema is nearly twice that of pneumonia.

The early recognition of empyema depends on constant attention, alertness and accuracy of observation. Repeated critical examinations with careful notations are of great value, especially when graphically indicated on a chest allowing a quick and easy comparison of findings. Two signs are of the greatest value, dullness and diminished or absent tactile fremitus, diminished breath sounds being next in importance. Dullness of flatness with the sense of resistance on percussion, together with the diminution or absence of tactile fremitus, were the most reliable signs. Careful watching of the cardio-hepatic angle, at times, gives information of importance. Any of the other signs may lead one astray. Bronchial breathing may be heard over fluid; whispered or spoken

voice may be increased when fluid is present. The heart may not be displaced even with considerable quantity of fluid. The trachea may be in median line. The fluid level may not shift with change of position. The signs may be looked for in any portion of the chest, as there is no place that the fluid may not accumulate.

The site for thoracentesis is the point where the signs are most definite without regard for location. Fluid has been aspirated from different pockets in the various locations just inside the right nipple, high and low in the axilla, near the sternum, beneath the clavicle, mid scapular region, and at the extreme base. An interlobar fissure must not be overlooked. The pocket formations may be the result of old or new adhesions. It has been possible in several cases in which yellowish gray pus was draining from a chest to find on thoracentesis, only a few centimeters away, a considerable quantity of slightly turbid lemon yellow fluid from another pocket.

The X-Ray has been of very great assistance not only in determining whether consolidation or pleural fluid was present but in locating the lesions with precision in the great majority of cases.

In the last of this series of cases, we did not operate on any case unless an X-Ray had been taken. The importance of this was demonstrated very clearly. We had operated an empyema on the right side and drained about a quart of pus, and some five or six days later, we located another pocket just below the clavicle. This is of invaluable aid in these cases. It is also of great value especially after influenza and pneumonia, assisting you as to whether your pneumonic process has entirely healed or not. An irregular temperature after pneumonia should always lead to careful scrutiny of the patient, a collection of pus not infrequently being found interlobar or in some other less usual location. At other times the temperature may be normal for many days and a pocket of pus by routine careful examination found and the patient thought to have an uncomplicated convalescence.

These cases were all proceeded by aspiration anywhere from a week to twenty-two days. Many of these were aspirated every other day. A patient was not considered fit for operation until his pus had become thick and his temperature had reached somewhere nearly normal. A thoracotomy was done in two cases with a very large pneumothorax, where the pneumothorax gradually progresses and the patient was in a very dangerous condition. In one of these cases thoracotomy was done when he had a pulse of 172 and a temperature of 106 degrees. Owing to the great alarm in this case, it was decided that he stood better chance with the thoracotomy. I cannot lay too much emphasis upon a routine aspiration of every case of empyema, with the exception of a case similar to the one I have just mentioned.

As soon as the diagnosis of empyema was made during the course of pneumonia, aspiration, using the Potain apparatus, was done, as a rule, every alternate day. This was continued until the pus became too thick for aspiration, for twelve to fifteen days. When the pneumonia process had subsided the advisability of operation was considered.

If the pus became too thick for aspiration and it was not considered that the patient's condition warranted operation, intrapleural lavage was practiced at the time of aspiration, in closed circuit, by connecting a bottle containing warm saline solution to the aspirating tubing. In this manner thick pus could be diluted sufficiently to permit aspiration. Care was taken at the time of all aspirations to prevent collapse of the lungs by admission of air. The operation was not performed until twelve to twenty days had elapsed.

All patients were operated upon by local anesthesia given an hour and a half before operation, and repeated again thirty minutes before operation, and a local anesthesia was used at the time of operation. The skin was prepared by ether, alcohol, followed by iodine. The chest was aspirated on the side of operation before the incision was made. A comparatively small

incision, large enough to permit an ordinary small size, Collins bone forceps was used. This made the operation rather difficult, but was of great advantage in the post operation treatment, enabling us to keep our dressing air tight. From an inch to an inch and a half of rib was resected, the pleura was punctured with a pair of scissors, the finger was introduced and explored the cavity as thoroughly as possible. It was very common to remove a sero-fibrinous exudate as large as my hand. A specially constructed Brewer tube with a Dakin tube was used. The ordinary Dakin tube extended into the pleural cavity from two to two and one-half inches. An Ewald stomach bulb was used for suction in twenty-four hours. Each patient was fully irrigated one a day, using from a quart to two quarts of Dakin's solution in small tube, allowing it to return to the large Brewer tube. This was continued until all pus was washed out and our solution was returned clear. An irrigation of the pleural cavity of patients should be watched very carefully as the large fibrous exudate may stop up the Brewer tube and the introduction of Dakin's solution to a closed cavity is a rather dangerous procedure. One patient of this series died during irrigation due to a large exudate stopping up the Ewald tube. The patient had an accumulation of pus in a pocket and the introduction of the Dakin's solution in some manner caused a paralysis of the heart and the patient died after a paroxysm of coughing.

After the pleural cavity is thoroughly washed out, a clamp is put on the small tube and the air is excluded from the pleural cavity and the Ewald bulb is left collapsed on the pleura for one hour. At the end of an hour from 100 to 200 cc of Dakin's solution is introduced, allowed to remain an hour. At the end of an hour the Dakin's solution is again removed and the Ewald bulb detached, and vice versa. At the last of this series we were unable to secure any large Brewer tubes, and the largest drain tube that we could find was used in its place and our wound left open, pay-

ing no attention to air. This method was used for four or five days, in a negative pressure for four or five days, and then our tube was changed and a Brewer tube was used in its place. The object of this was to get rid of the large fibrous exudate and as thoroughly free of drainage as possible.

Dakin's solution is of distinct value, both for its antigerminicidal properties, as well as solvent action in these cases. It not only dissolves the exudate, but aids the expansion of the lung by quickly removing the heavy plaques of fibrin from the pleural surface and preventing a fibrous thickening of the pleura, and is undoubtedly of great value in dissecting the large fibrinous exudates.

Drainage. This should be as free as possible at the most dependable location, an interior empyema should always be opened in mid-axilla if possible, and the abscess broken through. A drainage tube in the anterior chest, will, I believe, prove to be poor surgery. In the last ten cases of this series, no irrigation was used, as we were unable to obtain a fresh Dakin solution.

In summing up this series of cases, I cannot emphasize too strongly the value of the type as an aid in your prognosis. Second, repeated aspirations until the temperature gets as nearly normal as possible, the only condition in which you are not justified in following this procedure is a large progressive pneumothorax. An air bacillus in the tissues in these cases was common. Local anesthesia combined with morphine $\frac{1}{8}$ and hyoscine $\frac{1}{200}$ is preferable. Free drainage, the same as we had for any other cavity, is very important. The use of Dakin's solution is to be highly recommended, providing that you are able to obtain a fresh and pure solution.

Feeding an empyema patient is of great value and they should take at least 2,500 calories each twenty-four hours. The attending physician should continue his services with the surgeon, as complications, such as an extension of pneumonia on the other side, or re-infection of the affected

lung are recognized more promptly by the physician, who has observed the patient from the onset.

————— R —————

Non-Surgical and Surgical Treatment of Prostatic Obstruction of the Bladder

L. O. NORDSTROM, M.D., Salina, Kan.

Read at the Annual Meeting of the Kansas Medical Society held at Ottawa, Kansas, May 7 and 8, 1919.

The progress made in this branch of surgery is quite fully appreciated when we compare the treatment of twenty years ago with that of today. In a text book of surgery, published in 1898 by a prominent surgeon and teacher in this country, we find under the head of prostatic hypertrophy the following: "Treatment chiefly palliative, every source of irritation should be removed, bowels kept open, irritability of the urine diminished by the administration of alkaline diluents, venereal excitement prohibited, in gout and rheumatism judicious diet and medication may arrest or at least retard the progress of the disease in the prostate. In obstinate cases of retention and obstruction the propriety of operative interference beyond catheterization or puncture of the bladder may be entertained in a certain proportion of cases." Concerning prostatectomy this author goes on record by saying: "I have in all these cases declined to attempt any removal of the enlarged organ, but advised permanent supra-pubic drainage."

The position taken by this surgeon at that time was, no doubt, warranted because of the high mortality following prostatectomy.

Removing the obstructing prostate in the primary stage, or after proper preparation of patients suffering from the effects of secondary changes, and a high degree of technical skill of the operator have brought about a marvelous reduction in mortality and a notable increased state of health and usefulness of the patients.

In support of surgical treatment statistics from the most reliable sources show that the per cent of mortality due to catheter life exceeds that of prostatectomy

when done at the proper time by competent operators. J. Bentley Squier in reviewing a series of cases concludes that fifty per cent of unoperated patients will die within five years from the onset of obstructive symptoms where catheter life is not necessary, and that the beginning of catheter life shortens this expectation of life almost fifty per cent and increases the mortality to sixty-six and two-thirds per cent within the shortened period.

In the primary stage the symptoms of urinary obstruction are confined to the bladder and the urinary outlet therefrom such as frequency of urination, slowness of starting the urine, burning, pain and tenesmus. Slowly and progressively there is an increased retention of urine. The persistent presence of urine in the bladder produces secondary changes with the general symptoms of loss of appetite, dryness in the mouth, insomnia, loss of weight, loss of strength, etc.

The theory that the general symptoms depend upon the presence of residual urine in the bladder, and caused by the absorption of a highly concentrated urine has received due recognition. Many observers contend that infection is the chief causative factor. In my judgement the most logical explanation of the causation of the general symptoms is that of kidney insufficiency due to back pressure of the urine. It has been estimated that from 2 to 4 ounces of residual urine is quantity sufficient to cause back pressure on the kidneys and interfere with their function.

It is quite evident that prolonged obstruction from any cause which interferes with bladder evacuation will at first cause the bladder to contract upon its contents. This constant pressure against the orifices of the ureters will eventually result in dilatation of the ureters extending back to the pelves of the kidneys. Just what changes are brought about within the kidney as a result of pressure in its pelvis are probably not definitely understood. A consideration of the anatomy of the kidney suggests first, that the pressure in the pelvis interferes with the circulation of

the blood through the organ, since the afferent and efferent vessels are in such close proximity to the pelvis. Second, compression of renal tissue and disarrangement of the urinary tubules.

Infection is a very important factor in connection with the secondary changes taking place in patients suffering from the effects of obstruction of the bladder. It is extremely difficult to estimate the degree of infection as well as the degree of immunity possessed by the patient. Cystitis and a very purulent urine might suggest a very grave prognosis when the fact of the matter is many of these patients are better surgical risks because of established immunity. Some of these patients are apparently free from infection when we begin to relieve them of residual urine by catheterization, but in a short time there is a development of chills, fever and other evidences of sepsis notwithstanding a very close adherence to surgical cleanliness in the introduction of the catheter. We have reasoned that the infection was introduced, and have blamed ourselves for faulty technic, but now we find consolation in the following statement of Judd: "Many of these patients may have more or less chronic infection of the kidney from the beginning of urinary symptoms, but the kidney does not continuously pass organisms into the urine. An area of infection may be walled off so that the urine is free from pus and organisms except at intervals when the area opens up and discharges into the pelvis. Withdrawing of urine brings about changes in the kidney increasing infection and liberating pus."

Treatment. The obstruction should be removed during the primary stage whenever possible. Patients who have carried residual urine sufficiently long to cause secondary changes are entitled to preparatory treatment before operation. They should be put to bed on a liquid diet, chiefly milk, buttermilk, and large quantities of water and lemonade. Catheterize two or three times daily at first then leave the catheter in the bladder for continuous drainage. If catheterization is impossible,

suprapubic puncture of the bladder must be resorted to in order to establish drainage. As a rule, the withdrawal of urine precipitates a definite reaction by increasing the general symptoms of weakness, irritability, insomnia, anorexia etc. The blood pressure drops and the specific gravity of the urine falls. Chills, fever, and pus in the urine may show up during the reaction. This treatment should be continued until these symptoms subside or until there is a general improvement of the patient.

In estimating the ability of the patient to stand the operation of removing the obstruction, various laboratory tests might be employed to determine the retention of urinary solids in the blood, and the excreted solids in the urine, as well as the functional capacity of the kidneys to eliminate dyes. It is well to be on our guard so as not to overestimate the value of the laboratory findings. After all I believe the clinical tests of general physical improvement are of greater value in determining the time for operation.

Operation. The transvesical or suprapubic method seems to hold the vantage ground principally because it is easier to accomplish, it affords an opportunity to inspect the bladder for calculi and neoplasms, positively avoiding perineal fistulae, and the assurance of better functional results. After irrigating the bladder quite thoroughly, leave solution in the bladder to keep it moderately distended. Under general or local anaesthesia make a long suprapubic median line incision through the skin and fascia, separate recti muscles, free the fundus of the bladder from fat, push peritoneum away from bladder, swab prevesical space with tr. benzoin co. Open bladder high on fundus, insinuate index finger into urethral opening, break through capsule and enucleate the gland. Attend to excessive hemorrhage by suturing or packing cavity with gauze. Provide bladder drainage by a rubber tube the size of a large catheter or larger. A small drainage tube in the prevesical space is provided for and the wound closed.

Patient put to bed should be kept warm and dry. Saline solution per rectum. Bladder irrigation frequently through drainage tube to wash out blood clots. An ordinary glass syringe using 2 or 3 ounces sterile water is usually sufficient. Give patient water as soon as he awakens from the anaesthetic and calls for it. The following day liquid diet—milk, buttermilk, fruit juices, lemonades. After the second or third day general diet.

—————R—————

Fractures of Femur.

R. C. LOWMAN, M. D., Kansas City.

Read at the Annual Meeting of the Kansas Medical Society held at Ottawa, Kansas, May 7 and 8, 1919.

I do not intend to bring out any startling innovations in this paper but rather to review our knowledge of the subject with the object of making better diagnosis and instituting better treatment in many cases.

Starting with the neck of the femur, we know that most of these cases occur in elderly people, though they occur not infrequently in middle age and sometimes in childhood, where they may be of the green stick variety, may be unrecognized and later lead to the development of coxa vara.

A point of importance in elderly persons is that fracture may be caused by very slight violence, often by a trip over carpet or some object and subsequent fall to the floor. In fact, probably the fall is often caused by the fracture, which occurs before the patient strikes the floor.

Another thing of great importance is whether impaction has occurred or not, as impacted fractures unite much more often than the unimpacted variety. Those occurring near the trochanter are likely to be impacted, those nearer the head unimpacted.

Symptoms: There is usually great pain on moving or attempting to move the leg. The leg lies almost absolutely helpless and the patient can not raise the heel from the bed. The foot usually lies in a position of eversion and the toes can not be inverted, though in impacted cases the patient can sometimes invert the foot somewhat.

Shortening to some extent is nearly always present though at first it may be slight, and in cases not diagnosed the medical attendant may be astonished to find that in 4 or 5 days the shortening has increased to 2 or 3 inches.

In most cases there is a fullness in Scarpa's triangle and the fascia above the trochanter will be found much more lax than on the uninjured side.

The trochanter will be found to have ascended, and two lines are in common use to determine this point; namely, Bryant's line which is drawn from the anterior iliac spine vertically downward to the bed, and the distance from this line to the top of the trochanter noted on both sides; the other, Nelaton's line which is drawn from the anterior iliac spine to the tuberosity of the ischium and crosses the tip of the great trochanter when the thigh is slightly flexed.

If the fracture is not impacted, crepitus can be obtained by traction or rotating the leg. However, crepitus is the last thing to be looked for and ordinarily it is unwise to attempt to get it at all on account of breaking up an impaction and thus decreasing to a great extent, especially in elderly patients, the probability of obtaining union.

Measurement should be made from the anterior iliac spine to the tip of the internal malleolus. A slight difference in the length of the limbs is not uncommon and this should be taken in account, and in case of shortening the tibiae should also be measured and if of the same length it may be considered that the limbs are symmetrical and any shortening is indicative of some lesion of the thigh or hip.

In rare cases the fracture may occur in such a manner that impaction takes place in the anterior aspect of the neck and inversion of the foot takes place. In these cases one might consider a dislocation of head of the femur on the dorsum of the ilium, but in the latter case the head can be felt in its abnormal position, and the whole history and other signs will be different.

Lastly we have an invaluable aid in

diagnosis in the X-ray and we should always avail ourselves of its help whenever possible. We can ascertain the seat and extent of fracture, amount of displacement and have some idea as to amount of impaction. We will also be able to diagnose the green stick variety in children where the diagnosis is often missed, and the child allowed to develop coxa vara with permanently lime hip with restrictions of movement, and all because of failure in diagnosis and proper treatment. In elderly patients who are unable to use the limb after even a slight injury, it is best to consider a fracture present unless disproved by the X-ray.

There is considerable danger to life in fractures of neck of the femur because so many of them occur in feeble elderly people. Shock kills a few in two or three days, then hypostatic pneumonia may develop a little later, and some live several weeks and finally die of exhaustion. Union is most likely to occur in the impacted cases especially those near or extending into the trochanter. Union, of course, is more common in the more robust and younger patients. The rule though, is to have some shortening, more or less limp, and some restriction of movements. Some lives are made miserable by chronic rheumatism which prevents use of a hip which otherwise might do fairly well.

Some cases get along even with ununited fractures. A number of cases are recorded where by use of a bone peg, union has taken place and a useful limb secured, even weeks or months after receipt of the injury. This result is more likely to be secured in the younger more robust class of patients.

Treatment: The general treatment is of considerable importance. The patient should be made as comfortable as possible, and a well trained, capable, tactful nurse is a blessing.

Bed sores develop easily and should be guarded against by careful attention to bedding, keeping parts clean with soap and water followed by alcohol and dusted with some bland powder, as equal parts of

starch and zinc oxide or stearate of zinc.

Elderly people should be encouraged to move about in bed a little and even elevated from time to time on a bed rest.

If signs of hypostatic pneumonia show in the least it is sometimes wise to discard all apparatus and use the ordinary measures common in this condition, as it is absurd to use the most scientific methods if the patient dies in a few days because of such treatment.

There are a number of methods used in the treatment of fracture of neck of the femur and it is obviously impossible in a paper such as this to discuss all of them in detail. It is important, though to remember that in the use of any method the degree of success obtained is in direct proportion to the skill with which each is used, and the amount of unremitting care and attention given to the individual case. Any method used in a half hearted, careless manner will give a percentage largely of very poor results.

Another very important point is that unless one is treating this class of cases all the time it is wise to thoroughly read up on the case in hand, as the average doctor gets lamentably ignorant as regards both diagnosis and treatment, especially if he only sees a case once or twice a year.

The great majority of cases both past and present are treated by the simple traction method, and fairly good average results are obtained in the favorable impacted cases.

It is important to have a firm smooth bed which does not sag beneath the patient and this can be obtained in country practice by placing boards under the mattress from side to side. Eversion should be corrected as far as possible by gentle means, always bearing in mind that too forcible measures to correct eversion may result in breaking up an existing impaction, with resulting nonunion.

Long sand bags placed on each side of the leg and thigh give a feeling of security, prevent any sudden side movement and aid in correcting eversion. Treating the leg in a more or less everted position pre-

supposes that recovery will take place with the limb permanently in this position.

The amount of weight used varies according to different authors from 5 to 20 pounds. Enough should be used to steady the leg and prevent any further shortening from taking place. Leudder advocates a strap made of duck about 4 or 5 inches wide applied about the hip and pelvis. Two pads of leather are stitched to this pad about 4 or 5 inches apart and should rest behind and in front of the great trochanter. The strap exerts gentle direct pressure on the trochanter and the posterior pad helps support the femur and prevents a falling outward and helps to correct eversion.

Another method used considerably is known as the Maxwell method and has in addition to the longitudinal traction, a continuous lateral traction, which is also applied so as to help correct eversion.

First the fracture is reduced by flexing the thigh on the body while an assistant makes outward traction on the upper part of the thigh. The outward traction is maintained while the surgeon makes longitudinal traction and extends the thigh until it lies longitudinally on the bed. The two tractions are maintained until the weights are applied. From 20 to 30 pounds longitudinal pull is used and about two-thirds of that for the lateral pull. Warbasse says that no treatment is used that compares with this method. It makes the treatment simple and comfortable, union may be expected in every case. The aged need not be confined more than four weeks after which they may sit up most of the time.

The patient in most cases is allowed up in 6 or 8 weeks, but according to good authority should not bear weight on the injured hip even with the assistance of crutches, for about 4 or 6 months.

Many surgeons use the Thomas fixation method by means of the Thomas hip splint and obtain good results.

Whitman teaches that the proper treatment of most cases of fracture of the neck of the femur is to dress the leg in marked abduction by means of an extensive plaster

of Paris splint. In young adults he believes it wise to break up any existing impaction, in elderly patients treat impaction according to condition of patient. He states the abducted position adjusts and fixes the fragments at the same time.

The last method I shall speak of is that by pegging the fragments with a bone peg. Nails are not used very much at present, needless to say considerable experience and armamentarium are necessary in the use of the bone peg.

Fractures of the shaft of the Femur: These are often difficult cases to treat and get a good result. These fractures are generally oblique and the contraction of the large thigh muscles can rarely be completely overcome, and consequently, there is nearly always some shortening and bony distortion. Shortening of an inch or less is considered by many a very good result. Even with open operation the overlapping of the bone ends can rarely be completely overcome.

The weight used should be about all the patient will bear. Authorities differ on this point, one stating a pound each year up to twenty pounds, another says 15 or 20 pounds is generally enough, and another uses enough to overcome shortening up to 30 or 40 pounds, and even 60 pounds in some cases.

Fractures in the upper third of the femur are likely to be especially difficult to treat because of abduction and flexion of the upper fragment. The abduction can be met partly by splint pressure and partly by placing the whole leg in the abducted position and applying the extension while in this position.

The flexion is treated by the pressure of an anterior splint or the use of a single or double inclined plane or in the case of children by using vertical suspension.

—R—

Excerpts—By the Prodigal

"MEDICINE HAS GONE OUT OF STYLE"

So says Captain Hughes Walker, U. S. A., of the Surgeon General's Office, Washington, D. C., in the Ladies Home Journal for May, 1919.

In a previous number of this Journal, K. M. S., the Prodigal said: "In ye olden times, Medical Journals published little therapeutic helps, reminders, or memory refreshers for the general practitioner more frequently than they do now."

The Prodigal finds himself in a class with the four day old pups that a boy was selling at a Democratic rally as Democratic pups; and a month later was selling of the same litter of pups as Republican pups, and gave as a reason for the political change, "They had got their eyes open."

Dr. Mearns has put a cinch on the Prodigal's optics with good results. His periscopic mental sight has been visioned more acutely and he sees more clearly why therapeutic suggestions are not so common as "In Ye Olden Time," because "Medicine has gone out of style," and because the doctor of today knows so much less than the doctor knew forty years ago.

Forty years ago, figuratively speaking, there were forty medicines for each disease. Today there are forty diseases for each known remedy. The history of therapeutics is not unlike the history of theology. The ancients were polytheists in their beliefs. They had many gods to cure their spiritual infirmities. The theology now, that sticks and has the punch and is worth while is monotheistic—knows one God only. In medicine it is monotherapy that gets results.

"Medicine gone out of style," does not mean that medicine is obsolete any more than that God is obsolete. It does mean that medicine is better understood, has a sounder basis and a surer and more rational foundation, that reason is beginning to control and to take the place of ignorance, superstition—the buckeye and the rabbit foot. It means that the medical man has more knowledge and is applying wisdom in selecting from the mass of facts handed down from the ages for his use. Dr. Mearns' paper is titled "Doin' Nothing For Me." One kicker case to which the doctor calls attention was a fracture of the spine. "The patient complained because 'Nothin' dun for him.' There was no medicine

given him." The doctor said, "That was right. During the three months there was no record of a single prescription." The reason is simple; he had no need of drugs. There is no drug that will cure a fractured backbone, nor are there any that will cure pneumonia, tuberculosis, rheumatism, sciatica, heartache, homesickness or three quarters of the other ills flesh is heir to. If there were such, doctors would use them.

"Medicine has gone out of style." Nothing is more significant in the modern treatment of disease than that. A walk through the miles and miles of army hospital wards shows no array of bottles and spoons beside each bed. Our sick men are not getting a pill or tablespoonful of something bitter each hour, at which some of them wonder and sometimes feel neglected. No reputable physician nowadays gives medicine indiscriminately to every patient who applies. The modern doctor has lost his old time faith in drugs, for the simple reason that they do not always do what is claimed for them. We have found out that they frequently do more harm than good. A drug for instance while 'curing' a patient in the head may do permanent injury somewhere else. To take some drugs is like blowing up a city to put out a fire, or amputating a hand to save the trouble of washing it. The failure is not in or with the drug but in using the wrong drug in the right place. A doctor may be loaded down with facts, know the pharmacopoeia from a to z, but lack wisdom to select the right drug or to apply it properly or at the right time. And the crux of the matter is that a physician must realize his limitations as well as his possibilities. If he magnify the latter at the expense of the former he becomes a dangerous crank or a charlatan, while if he magnify the former at the expense of the latter, he becomes a pussyfooted nonentity.

There are but a few known medical remedies for disease. This was not believed a generation ago as a rule. The better class of the older physicians began limiting their use of drugs and avoiding shotgun prescriptions a quarter of a cen-

tury ago, but they had not reached the positive stage of advocating and enforcing their teaching; that which they vaguely believed and actually practiced.

"Medicine has gone out of style" for the up to date medical man who can stand the financial pressure or has an established prestige. But what is to become of the average doctor during the transitional stage which is upon us, during the educational period of enlightenment of the people, while the drug habits are being broken up, the weaning period? The old hymn reads: "I must fight if I would win. Increase my courage, Lord." But it's hard to increase the courage of a collapsed viscera or a slim pocketbook, however willing the spirit of the Shylock tabernacle of clay.

It is true that the indiscriminate prescribing of drugs by the physician is on the wane. As his knowledge increases he uses a newer, more rational and efficient treatment. As he eliminates drugs he substitutes physical manipulation and his mental personality. Disease means not at ease. The physician has learned that dynamic bodily mechanics will cure a percentage of bodily defects. That psychical contagion or the transference of functional health will relieve others. Hence the dual man is put at ease physically and mentally. This treatment in addition to dietetics and hygiene covers the practice of medicine with but few drugs.

The younger generation of physicians have caught on already as noted by the following class of persons and schools of medicine recognized by law to practice and teach medicine in the state of California, vis. Physicans and Surgeons, Osteopaths, Drugless Practitioners, Chiropodists, and Midwives. The naturopaths and hydro-paths have a free hand. A chiropractor was arrested and tried in a court in California for advertising and holding himself out as practicing a mode or system of treatment. The jury failed to convict him. The case served to advertise and increase the clientel of the Practor.

Advertising is turning the mind toward,

and the way to turn the mind of the public toward an ism is to fight it. All isms have a grain of truth in them. The regularly educated physician is prepared to extract the essence of truth out of the ism or pathy without using the camouflage, and he must do it and use it or he will be lined up soon with the once overs.

But there is no salvation for the stiff necked, foreordained to all eternity, inerant orthodox in medicine. His days are numbered and nature will soon time him and when too late he will see his error. But he will get to climb in over the divide, if by the skin of his teeth, although his works may follow him.—Selah.

The cigarette has been started on the toboggan in the school of agriculture of Minnesota. 280 of the 397 students decided to ban the cigarette. All of the students have agreed to live up to the decision. Giving up and getting rid of our ideal esthetic habits is as great an effort and causes us as much pleasure as pulling our eye teeth.

“Medicine has its personal equation. The classroom and the clinic are the only foundation stones, and the algebraic ‘x’ of medical practice indicates that any means are justifiable to save life or to render living worth while.”—Pharmacal Ad.

Skin grafting, according to Lexer and Davis, from others than the patient are, practically, never permanent.

Scientists are trying to locate the hunger germ. The sign is right, in the Zodiac.

There are so many airplanes in Southern California that the people are getting their tonsils sunburnt.

The Atlantic City Meeting

By ELVENOR ERNEST, M.D.

The American Medical Association meeting in Atlantic City was very successful in point of interest and number in attendance. The registration of approxi-

mately five thousand exceeded expectations. Hotel accomodations were at a premium and meeting places were overcrowded. The absence of uniforms was very marked, a very decided contrast to the meeting in Chicago last year.

The evening social gatherings, especially the reception to the President and foreign guests on Thursday evening, were unusually attractive, being held on the beautiful water front at Steel and Garden Piers. These foreign guests included men and women from France, England, Belgium, Italy, Scotland, Australia, Japan, Hawaii, Cuba, China, Greece, Sweden, Norway, India, Canada, Peru, Chile and Brazil, and had been entertained in New York City the week previous. At the banquet given in their honor at the Hotel Commodore, Sir St. Clair Thomson and Surgeon General Melis of the Belgian Army were received with particular favor and proved to be most witty and entertaining, sharing honors with our esteemed and popular Dr. Lambert. Sir Thomson reminded us, in responding to a toast, that “The English Hen is very proud of having hatched the American Eagle.”

The two days previous to the regular meeting in Atlantic City were filled to overflowing with other annual meetings touching medical interests, including the Medical Women's National Association, whose admittance requirement is membership in the American Medical Association. This organization is social rather than scientific, its contribution to the war has been the American Women's Hospitals, still serving in France, Serbia and the near East, to which one hundred and twenty-five thousand dollars have been given and two hundred and fifty thousand dollars additional pledged. The new work for the coming year contemplates a vigorous campaign of health propaganda following the Government plan. The meetings of the American Public Health Association were very popular, in fact preventive medicine seemed to be the dominating theme during the entire A. M. A. program.

A large number of interesting and beau-

tiful moving picture films were furnished by the Medical Department of the Army, The Bureau of Medicine and Surgery of the Navy and the United States Public Health Service, the latter showing two especially good pictures, "Open Your Eyes" and "Fit to Win." In addition a large number of private exhibits, including Dr. Baldwin Lucke's influenza microphotographs, Dr. Fenton B. Turk's experimental research plates and photographs, those by the A. M. A. Propaganda Department and many scientific subjects from various New York hospitals.

Perhaps at no other meeting have we had such a large and well arranged and attractive lot of medical exhibits. The commodious Steel Pier housed most of them. The Army exhibits, particularly the field X-ray, were popular. They were all good. War surgery, reconstruction work, industrial medicine and influenza divided honors, the latter finally elicited the newspaper comment: "Influenza still a Mystery to the World of Medicine."

The next meeting is to be held in New Orleans in April or May, 1920.

—R—

Genital Defects

H. Goodman, Camp Las Casa, Porto Rico (Journal A. M. A., March 29, 1919), has studied the genital and venereal conditions among the 12,000 troops in Porto Rico. He quotes from W. W. King a description of the climatic and racial conditions, as an introduction. Besides the various congenital and acquired defects, of which hydrocele seems to be the most common and almost an insular characteristic, he notices some of the more formidable disease conditions that are met with, such as frambesia, of which two cases were found, and the venereal diseases. One hundred and fifty-three cases of acute or subacute urethritis were found, some of which he suggests may have been acquired purposely to avoid service, when it became known that it was a disqualification for officers in the training camp. Urethritis has, in the island, an extended period of virulence, owing to the universal

practice of self-treatment, the milk of the cocoanut being considered as specific. There were 241 cases of chronic urethritis in the camp, and these sometimes underwent acute exacerbation after physical exercise or drill, if not treated. In only occasional cases was there posterior urethral involvement. Syphilis seems to differ in no way in its manifestations from that found in the United States. The total number of routine examinations of enlisted men was 211, of which 20 per cent gave positive Wassermanns. In twenty-two civilians, six, or 27 per cent, were positive. Details of treatment of venereal disease are given. After three months in camp during which the number of enlisted men rose from 250 to 12,000, only nine new cases of venereal disease were acquired. Police measures in the outside towns are described, and the data of venereal diseases among prostitutes are published and show what the results might have been without the isolating measures adopted. The infection seems to be very general among the disreputable classes, especially in the towns. More comprehensive reports of the examinations will be given later.

—R—

Armour Plant Open to Visitors

After being closed for two years due to government restrictions prohibiting visitors from the stockyards because of the war, Armour and Company's huge plant in the Chicago Stockyards is again open to visitors, an announcement from the company states.

This announcement will prove of interest to not only people who intend to visit Chicago some time this summer but to many others as well because, the announcement says, "preparations are being made by Armour and Company to open their other plants in various parts of the country so that a trip through a packing plant which is an educational one, will not just be limited to Chicagoans or visitors to Chicago, but to people in fifteen different parts of the United States, where Armour and Company have packing plants. Uniformed guides are in attendance to explain the various interesting things to be seen."

THE JOURNAL

of The

Kansas Medical Society

W. E. McVEY, M.D. - - Editor

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The Worst Is Yet to Come?

When the anti-narcotic law was passed physicians were given an exclusive privilege—that is, they were permitted to prescribe narcotics to their patients and permitted to purchase narcotics under certain forms and regulations. For this privilege they were required to pay an annual license fee of one dollar.

In the revision of the laws, for some reason, the annual license fee was raised to three dollars, beginning with January 1, 1919. Although they had paid one dollar each for their licenses for the year ending June 30, 1919, one dollar and fifty cents additional was collected for the half year, from January 1 to June 30, 1919, or at the rate of four dollars a year.

This item of fifty cents is a small matter to the individual physician, but amounts in the aggregate to about \$70,000 which the government has acquired by some technical interpretation of the law, evidently not intended by those who framed it.

Presumably one dollar should be sufficient to pay the expense of issuing a license, and few of us are able to explain the purpose of the additional tax. Is it a penalty? Is it to provide funds for the

prosecution of violators of the law? Or is it for revenue? The privilege is not productive of revenue to the physician who holds it, if he uses it in accordance with the law. If he abuse the privilege, there are laws for his prosecution and punishment.

While physicians may be regarded as having an exclusive privilege in the use of narcotics, they are also acting as servants of the government, assisting in the administration of the anti-narcotic law. It is a service, however, which the authorities, under whose jurisdiction these matters fall, seem to feel it is their duty to make as burdensome as the most technical interpretation of those laws will permit. A recent ruling of the commissioner has recently been mailed to the physicians of Kansas by the collector of internal revenue. It reads as follows:

"Wholesalers or manufacturers only can sell narcotics to registered persons and must require order forms. Dealer can sell narcotics on order forms in original packages only. Persons creating new package or repacking such drugs must register as manufacturer and affix stamps to package. Every individual tube of hypodermic tablets must be stamped, and not box containing such tubes. (Signed)

"ROPER, Commissioner."

It is quite easy to interpret a part of this ruling. It is quite plain that when a physician requires a solution of cocaine or some hypodermic tablets of morphia, he must fill out a blank form, send it to a wholesale house and wait until he gets it. He will have to buy the cocaine and make his own solution. A physician may write a prescription, give it to his patient and the patient can easily get the prescribed narcotics at any licensed drug store. But a physician is not permitted to buy it from the same druggist in any way. The ruling is very plain in regard to this point. A physician must get his narcotics—his cocaine or his morphine—from a wholesaler, but how much must he buy? What is an original package of hypodermic tablets—a box or a tube? At any rate this ruling

will necessarily prompt physicians to keep a much larger supply of narcotics on hand than heretofore.

Judging from recent reports, the anti-narcotic laws do not seem to have been as efficient as had been hoped, nor does the consumption of narcotic drugs seem to have been greatly diminished, and it will no doubt be necessary to draft still more rigid restrictions upon their sale and use. Possibly physicians will be compelled to make photographs and thumb prints and record the Bertillon measurements of those for whom they prescribe narcotics—as was proposed for the physicians in New York. Then, perhaps on account of the increased labor required of the government officials in filing and tabulating these records, the physicians will be required to pay a still higher tax for the privilege of making them.

—————R—————

Some Surplus

Not many of us realize the immensity of the task which confronted our government when it entered the war, nor do many of us get a fair conception of the great resources this country held. In glancing over a list of surplus property that the government has on hand and is now offering for sale to "recognized preferred sources," we note that there is a surplus stock of 20,928,782 pounds of canned peas. As there is only a surplus of 1,605,942 pounds of canned beans one naturally concludes that beans are more popular with our soldiers than peas. One would hardly believe there were so many peas in the world—they must have gotten most of them. One may also surmise that not all of the cooks were skilled in the fine art of pie making, for there is on hand a surplus of 5,597,918 pounds of canned pumpkin. But of that universal delicacy that so persistently appears on the menu in our state institutions—our penitentiaries, orphan homes, insane hospitals, particularly—prunes—there are 3,000,000 pounds left. How many prunes must there have been in order that 3,000,000 pounds should be left? When one

stops to think of the immense quantities that must have been accumulated, from which these items are only a part of the great surplus, he wonders where it all came from.

Of course every stock of food, or clothing, or chemicals, that was accumulated by the government was intended to serve some purpose, but in glancing over the list of surplus chemicals one naturally wonders what it could have been used for. In this list will be found a surplus of 740 tons of ether. Naturally we think of ether only as an anesthetic, and if we calculate that a half pound of ether is sufficient for the average anesthesia, there is enough left over to anesthetize 3,000,000 men. There is an item of 13,509 tons of phenol and one of 199 tons of aqua ammonia. For any of the uses that we as physicians are particularly familiar with, that much phenol and aqua ammonia would supply the demand for the next hundred years.

—————R—————

Prescribing Alcoholic Liquors.

The new regulations issued on June 30 by the Bureau of Internal Revenue, state that "Physicians may prescribe wines and liquors for internal use or alcohol for external use, but in every such case each prescription shall be in duplicate and both copies be in the physician's hand writing." Not more than one quart shall be prescribed for one person for a given time, and only for patients under the physician's constant supervision. The prescription must give the patient's name, his address, the condition or illness for which the prescription is given and the name of the pharmacist to whom it is to be presented.

This, however, does not apply to physicians in Kansas since the dry law does not permit pharmacists to sell alcoholic liquors under any conditions.

—————R—————

The Kansas Hospital Association will meet in Hutchinson on Friday, October 10. There are considerable possibilities in this association and if all the hospitals in the state would affiliate with it, much could be accomplished for the good of the profes-

sion as well as the people. The work of standardization can be much more easily carried out through such an organization, if it has the support of the hospitals generally.

—R—

Fables for the Kansas Doctor.

By RENNIG ADE.

Once upon a time there lived a Kansas doctor who was known in Wichita and Kansas City, Mo., as E. Z. Mark.

His name was listed as No. 7 on the Oil Prospectus, as No. 12 on the Florida Swamp Company, as No. 14 on the California Pecan Orchard, and as No. 23 on the New Zealand & Alaska Smelter Company. This meant that there were only seven, twelve, fourteen and twenty-three respectively more gullible individuals in the United States of America.

Sometimes he had as much as two hundred dollars ahead in the bank, and he would look hopefully at each stranger who entered his office. Usually he had to wait no longer than two or three days, when two smooth-shaven properous individuals would breeze cheerily in. The following program would follow:

"Is this Dr. Mark? Blink is my name—H. M. Blink of Blink & Stinger of Kansas City. Doctor, shake hands with Mr. Stinger. Mr. Stinger is president of the Gila Lizard Company of Arapahoe, New Mexico. Our plan is to cross the Gila lizard with your native jack-rabbit, thus securing a succulent meat, and combining the prolificacy and fecundity of the rabbit with the native inertia of the lizard. The product of this union should be a valuable food easy of capture. Your name has been handed to us as one we could rely upon to become interested in our proposition. We are permitted to have ten stockholders only in each city of less than one thousand inhabitants. We are also desirous of having you on our board of directors."

The latter argument always sold Doc a small block of the stock. That is, he would buy \$300 worth; \$200 down, and the company would carry him until fall for the balance at only 8 per cent. The banker,

who was a warm friend of Doc's, shaved the note \$25 that evening after business hours, and put the stock salesman next to another likely buyer.

Doc worked hard and managed to keep the children in school and let his wife go home every eight years on a visit. He belonged to all the lodges in town except one, the Rebekahs, and kept his dues paid up. Mysterious buttons and insignias stood out all over his person, and he had vowed and promised and sworn not to do any of the things that he had ever had any desire to do. Upon close inspection of his dead-beat patients he usually found them occupying high positions in one of his lodges.

He always figured that some day a dividend would be declared in one of his blue-sky ventures, but this never happened. The best he could ever do was to trade \$500 worth of old stock in the Pan-Hysterectomy Motor Co. for \$100 worth of stock in a company that was planning to open clothing stores in the Fiji Islands.

One day the Old Man with the Scythe came along, and with one long swing Old Doc was gathered in.

After a decent interval the estate was carefully invoiced. The old car sold for two hundred dollars, and the Liberty Bonds only had to be discounted 8 per cent. Fortunately there was only \$200 worth of the latter, so the loss was not great. The Automatic Typewriter & Harvester Company stock that had cost Doc five dollars per share was quoted at 11 cents and no buyers. The rest of his stocks were not quoted. With the little insurance, Mother managed to pay off the debts and make a respectable showing at the funeral. The obsequies were conducted by representatives of two or three lodges who read their parts and hurried through on account of the ball game which was to start promptly at two-thirty.

The consensus of opinion of the neighborhood was summed up in these words: "Doc was a good fellow but a damned fool."

Moral—If you would be properly invoiced, get out of the way.

BOOKS

The Higher Aspect of Nursing

By Gertrude Harding. 12-mo of 310 pages. Philadelphia and London: W. B. Saunders Company, 1919. Cloth, \$2 net.

The author believes that "No woman has a moral right to enter the nursing profession with purely selfish motives. There is a higher aspect of the profession which seems to have eluded many of those who enter upon it." The author warns the nurse in training against the evil influence of the physicians she comes in contact with and implies that the particular frankness with which the anatomy of patients is discussed is immodest and tends to lower the dignity of the nurses who permit it.

Training School Methods for Institutional Nurses

By Charlotte A. Aikens, formerly director of Sibley Memorial Hospital, Washington, D. C.; formerly superintendent of Iowa Methodist Hospital, Des Moines, and of Columbia Hospital, Pittsburgh; author of "Hospital Management," "Studies in Ethics for Nurses," etc. 12-mo of 337 pages. Philadelphia and London: W. B. Saunders Company, 1919. Cloth, \$2.25 net.

This text is prepared as a sort of guide for head nurses and instructors of nurses. It contains a good many valuable suggestions for the selection of good subjects for training and for the best methods to be adopted in teaching.

The whole training school system needs considerable revision and suggestions such as have been made by the author will, no doubt, receive proper consideration in the final standardization of the hospitals and hospital training schools.

An Outline of Genito-Urinary Surgery

By George Gilbert Smith, M.D., F.A.C.S., genito-urinary surgeon to out-patients, Massachusetts General Hospital. 12-mo of 301 pages with 71 illustrations. Philadelphia and London: W. B. Saunders Company, 1919. Cloth, \$2.75 net.

This is a very concise yet quite complete little work. Nothing of practical value seems to have been omitted. The procedures that are mentioned are those which the author has found most efficient in his own practice. The illustrations are excellent for so small a work and add very materially to its value.

The Medical Clinics of North America

Volume II, Number 4 (the New York number, January, 1919). Octavo of 303 pages with 60 illustrations. Philadelphia and London: W. B. Saunders Company, 1919. Published bi-monthly. Price per year, paper, \$10; cloth, \$14.

In the March number of the Medical Clinics of North America the clinic of Henry A. Christian takes first place, and he shows cases of cutaneous pigmentation with jaundice, palpable liver and spleen and ascites; and a case of fibrinous bronchitis. John Lovett Morse has a clinic on infantile scurvy. Dr. Wm. A. Graves presents a case of cancer of the uterine body. Dr. George R. Minot presents four very interesting cases of enlarged spleen. Dr. F. W. White has an article on "Improvement on the Medical Treatment of Chronic Ulcer of the Stomach and Duodenum." He at least seems to be fully impressed with the possibilities in medical treatment and says: "Medical treatment, properly used and with the new and more exact methods we now have for diagnosis and observation, will cure more chronic ulcers than surgery." He gives a detailed outline of his treatment.

There are many other very instructive articles in this number of the Clinics.

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Typhus Menacing World

War on typhus with a view to preventing the spread of the dread malady from Poland, where 100,000 persons are down with the disease, to other countries of eastern and southeastern Europe is planned by the League of Red Cross Societies of the World, the first health work on behalf of humanity which the organization, formed only three weeks ago, has set out to perform. News of anti-typhus plan, which is the result of a series of conferences between the Supreme Economic Council and Lieut. Gen. Sir David Henderson, director general of the League of Red Cross Societies, reached American Red Cross Headquarters last week.

Reports from Poland show that thousands have died from lack of medical care and that conditions in Hungary and other parts of eastern Europe, due to the ap-

pearance of typhus, are such as to constitute a menace to the rest of the world. Surveys made on behalf of the Supreme Economic Council show that the disease is spreading rapidly and that it will take a vigorous campaign to check it before cold weather sets in. Added to the menace of typhus is the danger of a cholera epidemic in these countries, the peoples of which are still suffering from the shock of war and undernourishment.

The Supreme Economic Council has appointed a committee of British, French and Italian representatives to confer with representatives of the League of Red Cross Societies, the object of this conference being the preparation of plans that will be submitted to the governments of the countries of eastern Europe. The necessity for immediate action will be presented to these governments. For its own part the League of Red Cross Societies has addressed an appeal to its founder members, the Red Cross organizations of the United States, Great Britain, France Italy and Japan, and to the Red Cross organizations of twenty-four other countries who have been invited to join the League, to hold themselves in readiness to participate in the campaign against typhus.

The division of duties between the League and the Supreme Economic Council has been arranged, it being agreed that the latter organization will place at the disposal of the League all the surplus medical and hospital supplies belonging to British and American armies and insure transportation of the same while the League will supply and maintain the personnel for the administration of the relief measures. The League of Red Cross Societies will also provide the best medical service and advice obtainable. In this connection the League will be in a position to use, immediately the anti-typhus plan receives governmental approval, the methods for combating typhus disclosed during the recent important conference at Cannes, where the world's leading physicians and public health experts were assembled.

In connection with the proposed cam-

paign against typhus, Lieut. Gen. Henderson, director general of the League said:

"If the Red Cross League is charged with the serious responsibility of protecting public health in this crisis, the people of the various nations must realize that the fight is their own and that the League is acting as their instrument.

"The League will be put to the severest test at the very beginning of its existence. We believe that with the aid of governments, and with the aid of voluntary national societies supported by the people, we can control and limit the spread of this epidemic so that Europe will be saved from disaster that would sure follow the spread of the disease. The situation in eastern and southern Europe is too serious to be coped with by any single government or by any voluntary society. The Red Cross League affords medium through which governments and voluntary societies can co-operate and by means of which efforts may be co-ordinated.

"The League has at its disposal the assistance of the most expert medical advisors, trained by practical experience in combatting typhus. It has already the help of the trained personnel of the American and the British Red Cross, both of which societies already have units in the field, and it can call for aid upon other Red Cross societies that are members of the League. It will be able to utilize under expert direction, certain medical and other supplies now in Europe owned by the Allied governments and national voluntary societies. With these means at its disposal the League is prepared to undertake the strategical direction of the campaign.

"This emergency has come upon the League at the outset while it is still in process of organization, but the League has not felt that it should avoid responsibility. If the League is requested to undertake this work by the respective governments it will offer an opportunity to the people to show through their National Red Cross Societies their practical interest in common welfare. The future will depend upon the response made to that appeal.

The League has no thought of over-riding national societies, on the contrary, it seeks to co-operate with them and to develop and stimulate them.

"The actual menace of typhus and cholera gives immediate opportunity to people to unite in performance of this urgent service for the world.

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Principal Causes of Death

The Census Bureau's annual compilation of mortality statistics for the death-registration area in continental United States shows 1,068,932 deaths as having occurred in that area in 1917, representing a rate of 14.2 per 1,000 of population. Of these deaths, nearly one-third were due to three causes—heart diseases, pneumonia, and tuberculosis—and nearly another third resulted from the following nine causes: Bright's disease and nephritis, apoplexy, cancer, diarrhea and enteritis, arterial diseases, influenza, diabetes, diphtheria, and bronchitis. The death-registration area of the United States in 1917 comprised 27 states, the District of Columbia, and 43 cities in nonregistration states, with a total estimated population of 75,000,000, or about 73 per cent of the estimated population of the United States. (The territory of Hawaii has recently been added to the registration area, but the figures given in this summary relate only to continental United States.)

The deaths from heart diseases (organic diseases of the heart and endocarditis) numbered 115,337, or 153.2 per 100,000 population. The death rate from this cause shows a noticeable decrease as compared with 1916, when it was 159.4 per 100,000. There have been fluctuations from year to year, but in general there has been a marked increase since 1900, the earliest year for which the annual mortality statistics were published, when the rate for heart diseases was only 123.1 per 100,000.

Pneumonia (including bronchopneumonia) was responsible for 112,821 deaths, or 149.8 per 100,000. This rate, although much lower than that for 1900 (180.5) or

for several succeeding years, is higher than that for any year during the period 1908-1916. The lowest recorded rate for pneumonia was 127 per 100,000 in 1914. The mortality from this disease has fluctuated considerably from year to year since 1900, the general tendency having been downward until 1914 and upward from 1914 to 1917.

Tuberculosis in its various forms caused 110,285 deaths, of which 97,047 were due to tuberculosis of the lungs. The death rate from all forms of tuberculosis was 146.4 per 100,000, and from tuberculosis of the lungs, 128.9. The rate from tuberculosis of all forms declined continuously from 200.7 per 100,000 in 1904 to 141.6 per 100,000 in 1916, the decrease amounting to nearly 30 per cent; but for 1917 an increase is shown. Until 1912 more deaths were due to tuberculosis than to any other single cause, but in that year and during the period 1914-1917 the mortality from tuberculosis was less than that from heart diseases, and in 1917 it fell below that from pneumonia also.

Bright's disease and acute nephritis caused 80,912 deaths, or 107.4 per 100,000. The mortality rate from these diseases has increased from 89 per 100,000 in 1900, with some fluctuations from year to year, and since 1914 the increase has been continuous.

Apoplexy was the cause of 62,431 deaths, or 82.9 per 100,000. The rate from this disease increased gradually, with occasional declines, from 1900 to 1912, and since 1913 the increase has been continuous.

Cancer and other malignant tumors caused 61,452 deaths, of which number 23,413, or 38 per cent, resulted from cancer of the stomach and liver. The rate from cancer has risen from 63 per 100,000 in 1900 to 81.6 in 1917. The increase has not been continuous, there having been three years—1906, 1911, and 1917—which showed declines as compared with the years immediately preceding. The decrease in 1917 as compared with 1916, however, was very slight—from 81.8 to 81.6. It

should be borne in mind that at least a part of the increase in the death rate from cancer may be apparent rather than real, being due to a greater degree of accuracy in diagnosis and to greater care on the part of physicians in making reports to registration officials.

Diarrhea and enteritis caused 59,504 deaths, or 79 per 100,000. The rate from this cause has fallen somewhat in recent years, having been 90.2 in 1913, and is much lower than the corresponding rate for 1900, which was 133.2. More than four-fifths of the total deaths charged to these causes in 1917 were of infants under two years of age.

Arterial diseases of various kinds—atheroma, aneurism, etc.—resulted in 19,055 deaths, or 25.3 per 100,000. The rate from these causes increased continuously from 6.1 in 1900 to 25.6 in 1912, since which year it has fluctuated somewhat without showing any pronounced change.

Influenza was responsible for 12,974 deaths, or 17.2 per 100,000. This rate is the highest shown for any epidemic disease in 1917, but is much lower than the corresponding one for the preceding year, 26.4 per 100,000. The influenza rate, which fluctuates greatly, was higher in 1901, when it stood at 32.2, than in any subsequent year prior to the occurrence of the recent epidemic.

Deaths from diabetes numbered 12,750, or 16.9 per 100,000. The rate from this disease, although slightly lower than in 1916, has risen almost continuously since 1900, when it was 9.7.

Next to that for influenza, the highest rate appearing for any epidemic disease in 1917 was for diphtheria, 16.5 per 100,000, representing 12,453 deaths. The rate from this disease was somewhat higher in 1917 than in the preceding year, when it stood at 14.5 per 100,000.

Bronchitis caused 12,311 deaths, or 16.3 per 100,000. This rate is lower than that for any preceding year except 1916, when it was 16.2. The proportional decline from 1900, for which year the bronchitis rate was 45.7, to 1917, amounting to 64 per

cent, was greater than that shown for any other important cause of death.

TYPHOID FEVER.

Typhoid fever resulted in 10,113 deaths, or 13.4 per 100,000. The mortality rate from this cause also has shown a remarkable reduction since 1900, when it was 35.9, the proportional decrease amounting to 63 per cent. This highly gratifying decline demonstrates in a striking manner the efficacy of improved sanitation and of the modern method of prevention—the use of the antityphoid vaccine.

MEASLES, WHOOPING COUGH, AND SCARLET FEVER.

These three children's diseases were together responsible for 21,723 deaths of both adults and children, or 28.8 per 100,000. The rates for the three diseases separately were 14.3, 10.4, and 4.2, respectively, as compared with 11.1, 10.2, and 3.3 in 1916. As in 1913 and 1916, the deaths due to measles outnumbered those resulting from either of the other diseases, but in 1914 and 1915 whooping cough caused the greatest mortality. In every year since and including 1910, as well as in several preceding years, measles has caused a greater number of deaths than scarlet fever.

External causes.

Deaths due to external causes of all kinds—accidental, suicidal, and homicidal—numbered 81,953 in 1917, corresponding to a rate of 108.8 per 100,000 population.

The greatest number of deaths charged to any one accidental cause—11,114, or 14.8 per 100,000—is shown for falls. The rate for this cause varies but slightly from year to year.

Next to falls, the greatest number of accidental deaths—8,649, or 11.5 per 100,000, resulted from railroad accidents and injuries. This rate is greater than the corresponding rates for 1914, 1915, and 1916 (10.7, 9.9, and 11.3, respectively) but is lower than that for any year from 1906, the first year for which deaths from this cause were reported separately, to 1913, inclusive.

Burns—excluding those received in con-

flagrations and in railroad, streetcar, and automobile accidents—were responsible for 6,830 deaths, or 9.1 per 100,000. The death rate from burns was greater than that for the preceding year, 8 per 100,000, and was also greater than the rate for any earlier year covered by the Bureau's records, with the exception of 1907.

Deaths from automobile accidents and injuries in 1917 totaled 6,724, or 8.9 per 100,000 population. This rate has arisen rapidly from year to year, but not so rapidly as the rate of increase in the number of automobiles in use.

Accidental drowning caused 5,550 deaths, or 7.4 per 100,000. This rate is considerably less than that for any preceding year since 1910, and is also decidedly below the average for the decade 1901-1910.

Deaths due to accidental asphyxiation (except in conflagrations) numbered 3,375, or 4.5 per 100,000. This rate is somewhat higher than that for any year during the preceding ten-year period.

Mine accidents and injuries resulted in 2,623 deaths, or 3.5 per 100,000. This rate is greater than the rates for the preceding three years and for 1912, but is lower than those for other recent years.

Deaths due to injuries by vehicles other than railroad cars, street cars, and automobiles numbered 2,326, or 3.1 per 100,000. The rate from this cause has declined somewhat during the past ten years, probably because of the decrease in the use of horse-drawn vehicles.

Deaths resulting from street-car accidents numbered 2,277, corresponding to a rate of 3 per 100,000. This rate is greater than those for the two years preceding and is the same as that for 1912, but is less than the rates for other recent years.

Machinery accidents caused 2,112 deaths or 2.8 per 100,000, a rate materially greater than that for any preceding year covered by the Bureau's mortality records.

Hot weather caused 1,964 deaths, or 2.6 per 100,000. This rate is considerably above those for most of the years covered by the Bureau's records, but is somewhat lower than 2.9 in 1916 and is far below

5.3 in 1911. The rate from this cause naturally varies greatly from year to year.

The number of suicides reported for 1917 was 10,056, or 13.4 per 100,000. This rate is the lowest shown for any year since 1903.

Other deaths due to external causes, including homicides, totaled 18,353, or 24.4 per 100,000.

The following table shows, for the death-registration area in continental United States in 1917, the total number of deaths and the death rate, by leading causes, together with the percentage which each cause contributed to the total:

Cause	Number	Rate per 100,000 Pop-ulation	Per Cent of Total
All causes	1,068,932	1,419.4	100.0
Organic diseases of heart..	115,337	153.2	10.8
Pneumonia (all forms) ...	112,821	149.8	10.5
Tuberculosis (all forms) ..	110,285	146.4	10.3
Tuberculosis of lungs....	97,047	128.9	9.1
Tuberculous meningitis ..	6,092	8.1	0.6
Other forms of tuberculo- sis.	7,146	9.5	0.7
External causes	81,953	108.8	7.7
Accidental falls	11,114	14.8	1.0
Suicide.	10,056	13.4	0.9
Railroad accidents and in- juries.	8,649	11.5	0.8
Burns (excluding those due to conflagrations) ..	6,830	9.1	0.6
Automobile accidents and injuries.	6,724	8.9	0.6
Homicide.	5,781	7.7	0.5
Accidental drowning	5,550	7.4	0.5
Accidental absorption of deleterious gases, ex- cept in conflagrations..	3,375	4.5	0.3
Mine accidents and inju- ries.	2,623	3.5	0.2
Injuries by vehicles other than railroad cars, street cars and automobiles..	2,326	3.1	0.2
Street car accidents and injuries.	2,277	3.0	0.2
Machinery accidents and injuries.	2,112	2.8	0.2
Effects of heat (other than burns)	1,964	2.6	0.2
Other external causes ...	12,572	16.7	1.2
Acute nephritis and Bright's disease.	80,912	107.4	7.6
Cerebral hemorrhage (apo- plexy).	62,431	82.9	5.9
Cancer.	61,452	81.6	5.8
Diarrhea and enteritis	59,504	79.0	5.6
Congenital debility and mal- formations.	56,973	75.7	5.3
Arterial diseases—atheroma, aneurism, etc.	19,055	25.3	1.8
Influenza.	12,974	17.2	1.2
Diabetes.	12,750	16.9	1.2
Diphtheria.	12,453	16.5	1.1
Bronchitis.	12,311	16.3	1.1
Measles.	10,745	14.3	1.0

Typhoid fever	10,113	13.4	0.9
Appendicitis and typhilitis.	9,429	12.5	0.9
Respiratory diseases other than pneumonia and bronchitis.	9,238	12.3	0.9
Hernia and intestinal ob- structions.	8,677	11.5	0.8
Cirrhosis of the liver	8,569	11.4	0.8
Whooping cough	7,837	10.4	0.7
Puerperal affections other than puerperal septi- cemia.	7,317	9.7	0.7
Meningitis.	6,890	9.1	0.6
Puerperal septicemia	5,211	6.9	0.5
Rheumatism.	4,456	5.9	0.4
Scarlet fever	3,141	4.2	0.3
Erysipelas.	2,866	3.8	0.3
Malaria.	2,387	3.2	0.2
All other defined causes...	147,235	195.5	13.8
Unknown or ill defined causes.	13,610	18.1	1.3

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Articles Relating to the New Status of Venereal Diseases in Medical Schools, Laboratories, Clinics and Hospitals

Asst. Surgeon Gen. C. C. Pierce, U. S. Public Health Service: "The Nation-Wide Control of Venereal Diseases." *Southern Medical Journal*, Birmingham, Ala., March, 1919, p. 130.

Asst. Surgeon Gen. C. C. Pierce, U. S. Public Health Service, and Major W. A. Sawyer, Medical Corps, U. S. Army: "Venereal Disease Control in the Military Forces and Civilian Communities." *American Journal of Public Health*, Boston, May, 1919.

Sir W. Osler: "The Campaign Against Syphilis." *Lancet*, London, 1917, i. 1787-1792.

O. S. Warthin: "The New Pathology of Syphilis." *American Journal of Syphilis*, St. Louis, 1918, ii. 425-452.

T. W. Murrell, "Responsibility of the Physician to the Syphilitic and Through Him to the State." *Virginia Mag. Monthly*, Richmond, Va., 1918-19, xiv. 129-132.

Leredde & Rubinstein: "Prophylaxe Medicale de la Syphilis: l'organisation des Laboratoires; necessite d'un Enseignement Technique." *Paris, Med.* 1917, XIX, 153-155.

J. H. Stokes: "The In-Patient Hospital in the Control and Study of Syphilis." *New York, 1916, Social Hygiene*, Baltimore, 1916, II, 207-231, Reprint.

L. W. Hamson: "The Education of Students in Venereal Diseases." *Edinburgh, M. J.* 1918. N. A. XXI, 138, 145.

William Allen Pusey: "The Sanitary Attack Upon Syphilis." *American Journal of Syphilis*, St. Louis, January, 1917, page 125.

H. H. Hazen: "The Teaching of Syphilis." *American Journal of Syphilis*, St. Louis, January, 1917, page 135.

Charles J. White: "The Place of Syphilis in Our Medical Schools and Hospitals." *American Journal of Syphilis*, St. Louis, January, 1917, page 144.

Lewellys F. Barker: "The Importance of a Knowledge of Syphilis, and Especially of Visceral Syphilis for General Medical Diagnosis." *American Journal of Syphilis*, St. Louis, January, 1917, page 149.

John A. Fordyce: "The Teaching of Syphilis." *The Journal of Cutaneous Diseases*, Chicago, November, 1917, page 717.

C. Morton Smith: "The Teaching of Syphilis in School and Hospital." *The Journal of Cutaneous Diseases*, Chicago, November, 1917, page 726.

Walter James Heimann: "The Teaching of Syph-

ilis in Undergraduate Schools." *The Journal of Cutaneous Diseases*, November, 1917, page 732.

Symposium on "Teaching of Syphilis," the *Journal of Cutaneous Diseases*, Chicago, November, 1917, page 741. Discussion by Dr. H. H. Hazen, Washington, D. C.; Dr. Harry G. Irvine, Minneapolis; Dr. A. Ravogli, Cincinnati, Ohio; Dr. Frank Edward Simpson, Chicago; Dr. Thomas W. Murrell, Richmond, Va.; Dr. Jay Frank Schamberg, Philadelphia; Dr. Harold N. Cole, Cleveland, Ohio; Dr. James Herbert Mitchell, Chicago; Dr. Isadore Rosen, New York City; Dr. Franklin W. Gregor, Indianapolis; Dr. John H. Stokes, Rochester, Minn.; Dr. Boleslaw Lapowski, New York City; Dr. John A. Fordyce, New York City; Dr. C. Morton Smith, Boston, Mass.; Dr. Walter J. Heimann, New York City.

Publications by the United States Public Health Service: (1) "A Manual of Treatment of the Venereal Diseases" (1919). (2) "Instructions to Medical Officers in Charge of State Control of Venereal Diseases, 1918." (Miscellaneous Pub. No. 19.)

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The Government's Campaign Against Venereal Diseases

The scope of the campaign which the Government is making in the effort to eradicate venereal diseases is best shown by the following extracts taken from a communication received from the Surgeon General of the United States Public Health Service.

When the Chamberlain-Kahn Act created the Division of Venereal Diseases in the United States Public Health Service and the great work of venereal disease control was inaugurated, the plan of procedure formulated was grouped under three headings, as follows:

1. Medical measures.
2. Law-enforcement measures.
3. Educational measures.

"The educational measures includes the dissemination of information by leaflets, lectures, exhibits, moving pictures, stereopticon views, and other means, among industrial plants, commercial institutions, clubs, libraries, community centers, schools, churches, the home, and every walk of life.

"The law-enforcement measures include encouragement of the closing of restricted districts; stimulating enforcement by state and municipal officials of laws and ordinances directed against prostitution in all its phases, the establishment and management of institutions for the rehabilitation of venereally infected persons, and the commitment to institutions of venere-

ally infected feeble-minded persons; urging the adoption and enforcement of laws and ordinances compelling the reporting of the venereal diseases, the prohibiting of quack advertising, and the sale of venereal disease nostrums; and other measures designed to prevent the spread of the venereal diseases.

"The medical measures include the establishing of clinics; securing hospital facilities for venereally infected persons; making available laboratory facilities for the scientific diagnosis of venereal diseases; securing wide distribution of arsenamine or similar products; obtaining the support of the entire medical profession by the reporting of their cases to the State Board of Health and the treating of venereally infected persons, in accordance with the best modern methods; securing the co-operation of druggists in refusing to dispense venereal nostrums and directing prospective purchasers of such remedies to venereal disease clinics, or reputable physicians; securing the co-operation of dentists and nurses in their respective fields of practice; and enlisting the interest and services of all medical, dental, and pharmaceutical schools, societies, and journals.

"Under Medical measures, the campaign was begun with the advertising media of the country. The 20,000 newspapers and magazines carrying advertising were appealed to for co-operation, with the result that up to the present, according to agreement cards received, and clippings made, approximately 140 only, or less than one per cent, are still carrying obnoxious advertising. In other words, more than 99 per cent of the newspapers and magazines in the United States carrying advertising are co-operating.

"The next step in the campaign was directed to the druggists of the country. Out of the 48,500 appealed to, results up to the present, by return agreement card, show the co-operation of approximately 28,000, or nearly 60 per cent.

"After the druggists, the 131,780 legally recognized physicians in the United States

were appealed to, with the result that agreement cards of co-operation have been received up to the present time, from approximately 60,000, or nearly 50 per cent.

"The campaign with the dental profession is just being launched; the campaign with the nursing profession and the training schools for nurses, is under way.

"The campaign with the professional schools, hospitals, medical, dental, and pharmaceutical societies and associations—national, interstate, state, county, and municipal—has just been begun by a letter addressed to the deans of the medical and allied colleges of the country."

The following is a copy of the letter referred to:

Sir: The campaign for the control of venereal diseases in the United States by the Public Health Service makes it necessary for the medical, dental, and pharmaceutical schools, the hospitals, clinics, and the training schools for nurses, to co-operate to the utmost.

How may this be accomplished?

1. By calling a convocation of faculty, staff, and student body, at which:

(A) The dean will preside, state the object of the meeting, (viz., to indorse the propaganda undertaken by the U. S. Public Health Service, by direction, and under the authority, of Congress) and to appoint proper committees to put into effect the recommendations made by the chosen speakers, as to changes in curricula, etc.

(B) Selected speakers will deliver addresses on:

1. The sanitary attack upon the venereal diseases.

2. The better teaching of venereal diseases in schools, clinics, and hospitals.

3. The place of venereal diseases in our medical, dental and pharmaceutical schools, in our hospitals, in our clinics, and in our training schools for nurses.

4. The importance of a proper knowledge of venereal diseases, not only to physicians, but also to dentists, druggists, and nurses; further, to college physical directors.

II. By giving exhibitions to faculty,

staff, students, and nurses, of the official Public Health Service educational six-reel photo-drama films:

(a) "Fit to Win" for men, which will be furnished free on application to your State Board of Health, or to this Bureau.

(b) "The End of the Road" for girls and women, which will be furnished free on application to the Boards of Health in the states of Connecticut, Illinois, Louisiana, and Virginia, or which may be had under pay arrangement from Mr. Isaac Silverman, Room 211, 1493 Broadway, New York City.

III. By arranging meetings to be addressed by:

(a) The president of the State Board of Health on the activities within the state, either by the state alone, or by the state in co-operation with the Public Health Service; the subjects explained being medical (the establishing of clinics,) educational, legislative, social, law-enforcement.

(b) By the local, municipal, or county health officer, who will detail the local activities on the same subjects.

(c) By the Public Health Service representative appointed to your state to work in co-operation with your State Board of Health, who will speak on the same activities, especially the establishment, organization, and general policy of the free clinics for the treatment of venereal diseases.

(d) By the U. S. Public Health Surgeons in charge of the clinics already established in your state, who will explain about location, staff, equipment, laboratory, treatment, records, etc.

IV. By complete, permanent exhibits of official literature issued by:

(A) The U. S. Public Health Service:

1. Medical: reprints from U. S. Public Health Reports.

2. Educational: miscellaneous publications issued by the Division of Venereal Diseases.

Public Health Service literature will be furnished free for distribution to faculty, staff, student body, and nurses, on individual application to the Surgeon Gen-

eral, indicating list and quantity desired.

(B) State Boards of Health:

These publications are generally miscellaneous and may be had free on application to the State Board. Some states issue a weekly or monthly bulletin.

The campaign among the medical, dental, pharmaceutical schools, hospitals, and training schools for nurses having been recently launched in Washington, and all the universities, both white and colored, in the District of Columbia having already adopted the program, for your guidance in the plan outlined above, there is inclosed herewith the report of the proceedings of the Georgetown University convocation, including the recommendations made by Dean George M. Kober, of the Department of Medicine.

There is also inclosed herewith a list of articles which were published in the various leading dermatological and syphilitic journals of the United States within the last two years, upon the subjects mentioned above, to facilitate the short addresses.

A set of official literature consisting of (1) reprints from the "Public Health Reports," (weekly bulletin of the Public Health Service,) and (2) miscellaneous publications issued by the Division of Venereal Diseases, is being mailed under separate cover.

In view of the foregoing exposition, what co-operation may the Public Health Service expect from your institution?

Your early reply with any suggestions you wish to make will be awaited with interest.

Respectfully,

RUPERT BLUE,
Surgeon General.

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Birth Statistics

In the birth-registration area of the United States 1,353,792 infants were born alive in 1917, representing a birth rate of 24.6 per thousand of population. The total number of deaths in the same area was 776,222, or 14.1 per thousand. The births exceeded the deaths by 74.4 per cent. For every state in the registration

area, for practically all the cities and for nearly all the counties, the births exceeded the deaths, in most cases by considerable proportions. The mortality rate for infants under one year of age averaged 93.8 per thousand living births. The foregoing are among the facts brought out by the Census Bureau's annual compilation of birth statistics.

The birth-registration area, established in 1915, has grown rapidly. It comprised, in 1917, the six New England states, Indiana, Kansas, Kentucky, Maryland, Michigan, Minnesota, New York, North Carolina, Ohio, Pennsylvania, Utah, Virginia, Washington, Wisconsin, and the District of Columbia, and had an estimated population of 55,000,000, or about 53 per cent of the estimated total population of the United States in that year.

The birth rate for the entire birth-registration area fell below that for 1916 by two-tenths of one per thousand population; but the death rate was less by six-tenths of one per thousand than in 1916. Thus the excess of the birth rate over the death rate for 1917, which amounted to 10.5 per thousand, was somewhat greater than the corresponding excess for 1916, 10.1 per thousand, although it fell slightly below that for 1915, 10.9 per thousand. If the birth and death rates prevailing in any one of these three years were to remain unchanged, and if no migration were to take place to or from the area to which they relate, its population would increase at the rate of slightly more than 1 per cent per annum, or a little more than 10 per cent in a decade. This would be about half the rate—21 per cent—by which the entire population of the United States increased between 1900 and 1910.

Of the total number of births reported, 1,280,288, or 24.5 per thousand, were of white infants, and 73,504, or 25.8 per thousand, were of colored infants. The death rates for the two elements of the population were 13.7 and 22.5 per thousand, respectively.

The infant mortality rate—that is, the number of deaths of infants under one

year of age per thousand born alive—throughout the birth-registration area as a whole was 93.8 in 1917, as against 101 in 1916 and 100 in 1915. This is equivalent to saying that in 1915 and 1916, of every ten infants born alive one died before reaching the age of one year, whereas in 1917 the corresponding ratio was a trifle more than one in eleven. Among the twenty states these rates ranged from 67.4 for Minnesota to 119.9 for Maryland; and for the white population separately the lowest and the highest rates were 66.3 for Washington and 109.5 for New Hampshire.

The infant mortality rates vary greatly for the two sexes and for the various nationalities. The rate for male infants in 1917, 103.7 per thousand living births, was nearly 25 per cent greater than that for female infants, which was only 83.3. When the comparison is made on the basis of race or nationality of mother a minimum of 66.2 per thousand births is shown for infants with mothers born in Denmark, Norway, and Sweden, and a maximum of 172.6 for infants with mothers born in Poland, while for negro children the rate was 148.6.

The reports from the registration area show the birth of 14,394 pairs of twins and 155 sets of triplets in 1917—in all, 29,253 infants, or a little more than 2 per cent of the total number born.

The reports for 1,241,722 of the births occurring in 1917 contained information as to number of child in order of birth. Of these reports, 339,042 were for the first child born to the mother, 264,044 for the second child, 191,528 for the third, 134,331 for the fourth, and 95,931 for the fifth. In the remaining 216,846 cases, or 17.5 per cent of the entire number for which information upon this point was obtained, the total number of children borne by the mother was six or more; in 37,914 cases it was ten or more; in 1,600 cases, fifteen or more; in fifty-six cases, twenty or more; and in one case, that of a colored woman, the birth of a twenty-fifth child was reported.

The total number of children borne by the mothers who gave birth to these 1,241,722 infants in 1917, in whose cases data were available as to previous births, was 4,093,908. The reports for 1,194,621 of the births occurring in 1917 contained information as to the entire number of children borne by the mothers and still living, and gave a total of 3,443,466, or an average of nearly three living children in each family in which a birth took place in 1917.

————— I: —————

A Normal Shoe for a Normal Foot

Can the shoemaker build a shoe that will keep normal a normal foot? And having built it will the public be brought to see the beauty of the product? Not so many years ago we gave our admiration to the small, tightly laced waist. Today we laugh at it and tomorrow we shall be equally amused by the pencil-point toes and high heels that tilt the human foot to the angle of a horse's hoof. The war made low heels beautiful on Fifth Avenue, and consequently on Main Street; if it had lasted a little longer, women would, of necessity, have gone the whole way with the shoe problem. The shoes of the future will not be "prescription" shoes, they will not cater to deformities, but they will be built to conform to the normal lines of the foot.

The national board of the Young Women's Christian Associations through the health division of the Bureau of Social Education has started a drive to get this shoe for American women and to popularize it. The associations have all the health arguments. They have a national membership of four hundred thousand women to listen to them, but they cannot get this shoe without the co-operation of the manufacturers and dealers who make the shoes and determine the styles. To bring about this co-operation, a conference with leading shoe men was held recently at the National Board Y. W. C. A. headquarters in New York.

The manufacturers have a difficult problem, but not an impossible one. They must produce a low shoe, with a low heel and a

flexible shank that will allow enough exercise of the muscles of the arch to keep them strong, a shoe with enough room for the toes and a straight inner border because the foot is naturally straight on the inner side. They must make the shoe attractive to the discriminating taste by using their knowledge of leathers to procure variety and fineness of finish for both day and evening wear. Will the shoemaker do it? When he does, the national board of the Young Women's Christian Association will be back of him. Every woman who wants to wear the "normal line" shoe must be able to get it. All samples of shoes will be examined, an alphabetical list made, according to states and cities, of all the firms that carry these shoes.

This list will then be sent to local associations all over the United States, so that no one can say, "We would like to get these shoes, but we do not know where to find them."

————— I: —————

United States Pharmacopœial Convention of 1920

Article VIII, Chapter I of the By-Laws of the United States Pharmacopœial Convention provides that the president "shall issue, on or about the first of May of the year immediately preceding that of the decennial meeting, a notice inviting the several bodies, entitled under the constitution to representation therein, to send delegates to the next meeting. He shall repeat the notification, eight months later, and shall request the medical and pharmaceutical journals of the United States to publish the call for said meeting."

Article II of the constitution provides: "The members of the United States Pharmacopœial convention, in addition to the incorporators and their associates, shall be delegates elected by the following organizations in the manner they shall respectively provide: Incorporated medical colleges, the medical schools connected with incorporated colleges and universities; incorporated colleges of pharmacy, and pharmaceutical schools connected with in-

corporated universities; incorporated state medical associations; incorporated state pharmaceutical associations; the American Medical Association, and the American Chemical Society; provided that no such organization shall be entitled to representation unless it shall have been incorporated within and shall have been in continuous operation in the United States for at least five years before the time fixed for the decennial meeting of this corporation."

Section II of the constitution provides: "Delegates appointed by the surgeon-general of the United States army, the surgeon-general of the United States navy, and the surgeon-general of the United States marine-hospital service, the secretary of agriculture, the secretary of commerce and labor, the Association of Official Agricultural Chemists, the Association of State and National Food and Dairy Departments, the National Wholesale Druggists' Association, and the National Dental Association, and by the organizations not hereinbefore named which were admitted to representation in the convention of 1900, shall also be members of the corporation. Each body and each branch of the United States government above mentioned shall be entitled to send three delegates to the meetings of this corporation. But no such delegates as are provided for in this article shall be members until their credentials shall have been examined and acted upon as provided for by the by-laws."

In the discharge of the above required duties I hereby ask all competent and designated bodies and authorities to name and issue credentials to the fixed number of delegates to the tenth decennial convention to meet in Washington, D. C., on the second Tuesday of May, 1920, at 10 o'clock a. m., at a hall to be designated hereafter. The appointed delegates are requested to promptly forward their credentials to Noble P. Barnes, M.D., the Arlington Hotel, Washington, D. C., assistant secretary of the convention, who will file them for consideration of the committee

on credentials which will be appointed by the president not later than March 1, 1920, according to the requirements of Chapter VII, Article I of the by-laws.

Done at Washington, D. C., May 5, 1919.

HARVEY W. WILEY,

President of United States Pharmacopoeial Convention.

—————R—————

Chronic Morphinism

A. G. DuMetz, Washington, D. C. (*Journal A. M. A.*, April 12, 1919), reviews the literature of the attempts to account for the increased tolerance shown by chronic morphin addicts. He finds that the oxydimorphin theory of Marme and others is untenable, as has been shown by other observers. The Faust theory that the body becomes enabled to destroy morphin to a greater extent after continued usage, which theory has received some acceptance, is not conclusive, although that morphin is destroyed in the body to a certain extent there is no doubt. There is considerable evidence that it is destroyed in increasingly large amounts during the course of the tolerance. It does not necessarily follow that this is the cause of the tolerance acquired, for it may be only a concomitant phenomenon, as Cloetta holds, who attributes it to an increased power of resistance of the protoplasm to the action of morphin. The question seems to have been settled by Rubsamen in 1908, who found that rats that had been immunized to large amounts of the drug until they could stand double the lethal dose showed at a given moment the presence in their bodies of sufficient morphin to produce toxic effects in animals unaccustomed to the drug. He therefore advanced the theory that in addition to the increased power to destroy morphin the tissue cells became less sensitive to the drug. This theory has been accepted in principle by Van Egmond and Van Dongen. An entirely different explanation has resulted from the work of other experimenters. Gioffredi found that serum from tolerant dogs protected kittens against the fatal effects of from two to two and one-

half times the minimum lethal dose, and therefore that an antitoxic substance is formed in the blood. Other ideas have been advanced, more or less supported by experimental evidence, but the results obtained are more or less contradictory, though as a whole they leave the impression that there are reasons for the belief in some sort of immunity, possibly of the second order as described by Ehrlich. While the identity of an antomorphin toxic substance has not been established, up to date, it is not in keeping with our theory of immunity to call it an antitoxin. The majority of the theories offer no explanation of the abstinence or withdrawal phenomena to account for which other modifications of the theories have been proposed. All investigators have failed to show the exact nature of the factors that enable the system to tolerate enormous doses or identify the substances that cause the withdrawal phenomena. "The only knowledge of a positive nature that we really have at present concerning these problems is that the different organs and centers of the body acquire tolerance to morphin and heroin to a different degree and with various degrees of readiness; that these drugs as such are excreted in the feces in diminishing amounts during the period of acquiring tolerance; and that there is evidently present in the blood serum of tolerant animals (dogs) during periods of abstinence a substance or substances which, when injected into normal animals of the same species, causes the appearance of symptoms identical with the so-called withdrawal phenomena. Whether or not the disappearance of these drugs from the feces is due to their increased destruction in the organism is still an unsettled question. Attempts to solve this problem through a chemical examination of the excretions have led only to confusion, the literature being replete with contradictory results. Furthermore, it has not been proved that the destruction of morphin in the organism, if it does take place to an increased degree, is a causative factor in the production of tolerance. As

stated before, it may be only a concomitant phenomenon."

————— R —————

Lymphocytes and Cancer

L. D. Bristol, Augusta, Maine (Journal A. M. A., April 12, 1919), offers a theory of the function of the small mononuclears in the blood and their relation to cancer. He describes the development of the blood cells in the embryo, showing that of the white cells the first to appear (about the tenth week of embryonic life) is a cell corresponding to the lymphocyte; and it is only logical that the cell which possibly has to do with growth energy should appear before the polymorphonuclear cell or phagocyte which has to do with the protection of the body against injury. At the time when body growth reaches its maximum, the polymorphonuclears are in the majority, while at the same time the special lymphoid tissues (such as the thymus) which have to do with growth, rapidly atrophy. "It appears, therefore, that the lymphocyte possibly may be described as the male cell of the blood, and that through a process which is as yet not thoroughly understood, it has the power by means of the enzymes of its mass of nuclear material to energize the body cells with which it comes in contact, causing them to grow and divide. It is probable that the lymphocyte, or its energy substance, is under the constant control of an antibody, and that under normal conditions the influence of the lymphocyte and its enzymes is regarded for the exact demands of the body cells and tissues in their regular growth and division or to meet the special requirements of increased local repair at points of injury." It is Bristol's belief that as the controlled lymphocyte may be the potential father of normal body cells, so the uncontrolled lymphocyte may be the potential father of tumor cells. The potential mothers of tumor cells are the epithelial cell, the connective tissue cell, the muscle cell or other tissue cells. The offspring of such unions may be tumor cells, themselves, or cancer, sarcoma and myoma cells. He compares the blood cells

to the defensive forces of a country, the phagocytes constituting the standing army and the lymphocytes the army of reconstruction. Thus cancer may be due to two factors—a local cell stimulus set up by the energy-bearing lymphocytes concentrated by local injury, and a general loss of lymphocytic control due to an acquired or possibly a hereditary lack of antibodies. He gives references to the literature concerning this general view, and says that experiments are being carried on in the laboratory of the Maine Board of Health in order to discover possible means of controlling lymphocytes and cancer. These experiments will be described later in another article.

R

Magnesium in Cancer

S. Itami, New York (Journal A. M. A., March 29, 1919), notices a recent article by Dubard recommending the use of magnesium salts for patients after operation for cancer to prevent recurrence, and recalls former similar recommendations. He remarks that it is fortunate that experimental cancer research permits such suggestions to be tried out in the laboratory where animals are available, rather than testing them at the risk of human life. He mentions three types of mouse cancer, two of which are transplantable. One of them (Bashford's 206) often recedes after several weeks' growth. He found that the intravenous injection of magnesium chloride, even in doses relatively five or eight times as large as that fatal for man, was without effect on this type of mouse cancer, although two or three treatments were given within two or three days. Not only were there no tumors cured in 175 animals, but in one, which was being injected with a view to preventing if possible the recurrence of a spontaneous neoplasm, previously extirpated, a secondary growth appeared about three weeks after the eighth injection, and furthermore a new spontaneous tumor arose during the treatment. The true carcinoma nature of the tumors in all cases was tested microscopically. Since mouse carcinomas are

quite comparable to those of men in their behavior, these results would seem to throw doubt on the value of magnesium in the treatment of human neoplasms. In fact, Itami says, the assertion may be ventured that it is useless for such a purpose.

R

Varicocele

W. A. Angwin, Philadelphia (Journal A. M. A., March 29, 1919), says that varicocele is a frequent cause of disability in the navy, on account of the complaints of reflex or psychic nature attributable to it. Size alone is not an indication for operation, as it is frequently symptomless, while local pain or psychic disturbances, anxiety or worry over a possible defective genital condition may warrant an operation. The operation is divided by Angwin into six steps: the incision; the bringing of spermatic veins in view without disturbing the vas or its circulation; use of crushing hemostats to the veins; securing the cord with a non-slipping ligature; the further disposal of the cord; closing the superficial tissues, and providing suspension of the testicles. Most operative methods include lifting the cord from its bed which increases the post-operative induration. Induration, itself, should be a rare sequel. The spermatic artery is excised with the spermatic veins without attempting to separate it. He quotes the authority of Bevan as to there existing two sources of blood supply for the testis, namely the spermatic vessels, and the other vessels accompanying the vas, either of which suffices. The article is fully illustrated.

R

Lieutenant Commander R. B. H. Gradwohl, Medical Corps, U.S.N., R.F., has returned from the service and resumed his work as director of the Gradwohl Biological Laboratories and Pasteur Institute of St. Louis. Owing to the efficient organization of the Gradwohl Laboratories, they were not closed during the war period; and now that Dr. Gradwohl has returned, the profession is assured that renewed efforts will be made to assist all those who are in need of laboratory aid.

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Blood Chemistry.

The value of blood analysis has been studied by A. O. Gettler and A. V. St. George, New York, who publish the results of some 15,000 determinations in the *Journal A. M. A.*, Dec. 21, 1918, summarizing their conclusions substantially as follows: Kidney function may be ascertained by the increased value of nonprotein nitrogen, urea nitrogen, creatinin and uric acid; that is, whether there is a derangement in the elimination of the waste nitrogenous products, and its degree of severity and prognosis. Hyperglycemia can be detected with certainty by the increased volume of the blood sugar content, even in the very earliest stages of diabetes before sugar appears in the urine, and a blood sugar determination is therefore advisable. Acidosis and its degree can be shown by the decreased value of alkali reserve in the blood as measured by the Van Slyke method. Diagnosis in general is impossible with the blood picture alone. Only three conditions can be ascertained: First, an extremely high retention of nitrogenous substances means a renal involvement; second, a high persistent blood sugar means a diabetic condition or a tendency toward it, and third, a low alkali reserve means acidosis. Slight increase in nitrogenous values are not characteristic because they are found in various conditions, but as an aid in diagnosis to the general clinical picture, blood chemistry is most valuable. By reducing in the food of the patient the precursor of the particular substance found in excess in the blood, very good results are obtained, especially in carbuncles and allied conditions, where the blood sugar is abnormally high, and reduction of carbohydrates in the diet clears them up beautifully. In undiagnosable mild symptoms, in otherwise healthy persons, blood analysis may reveal abnormalities that can be corrected by diet. Abnormally high values for nitrogenous high waste products is not always due to kidney deficiency. When only slightly higher than usual a nonprotein nitrogen may be due to a great destruction of body protein or a deficient

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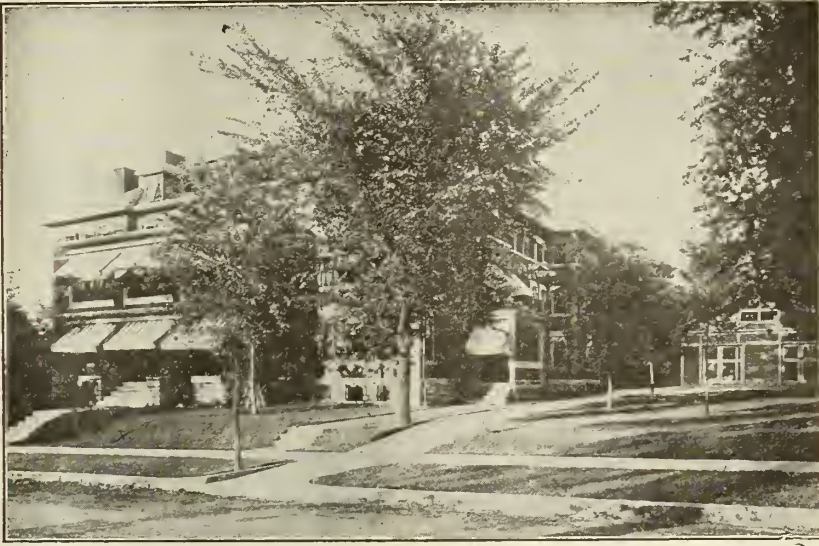
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circulation. In cases where the nonprotein nitrogen is very high, 80 or above, in the author's estimation, the only cause is kidney involvement. Fat and cholestrin experiments are being made and will be reported on later.

—R—

Radium Treatment of Arthritis Deformans

According to New and Nonofficial Remedies it has been claimed that radium emanation is of value in all forms of nonsuppurative, acute, subacute and chronic arthritis (syphilitic and tuberculous excepted), in chronic muscle and joint rheumatism (so-called), in arthritis deformans, in acute and chronic gout, etc. Its chief value is in the relief of pain. Curative results seem to be lacking.—Journal A. M. A., April 26, 1919, p. 1245.

—R—

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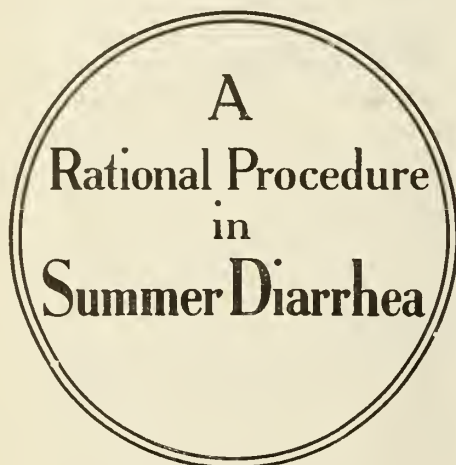
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No. 8

A Study of 750 Obstetric Cases in Private Practice

By E. A. REEVES, M.D., Kansas City

Read at the Annual Meeting of the Kansas Medical Society, Ottawa, May 7 and 8, 1919.

In presenting a study of my private obstetrical work I do not expect to bring out anything new or startling, but as hospital records and statistics in obstetrical work are not always accurate, and thinking that possibly a careful study of a small number of cases attended by one man might be of more value than a much larger number who were attended by many and whose records were less complete, I have tried to make my records complete and in the main they can be depended upon as such.

Of this series, 244, or approximately 32 per cent, were primipara, ranging in age from 15 to 37 years, the oldest patient in the list was a twelve-para, 47 years old.

In this series are 101 repeaters, fifty-three appear twice, thirty-three three times, eleven four times, and four five times.

PRESENTATION.—The presentation was noted in the first or second stage of practically all of the cases. I did not note in my records, occipito, right and left, but just occipito anterior or occipito posterior, which is as follows:

Occipito anterior...	691	92%
Occipito posterior...	19	2½%
Face	1	⅓ of 1%
Transverse	13	2%
Breech	26	3½%

This is much lower in occipito posterior and much higher in transverse than Mil-

ler's series reported in the American Journal of Obstetrics, May 19, 1918, but corresponds very closely with William's statement in his book, of 95 per cent occiput presentations.

FORCEPS.—I have used the forceps 88 times, or in about 11½ per cent of all cases. Fifty-eight of these forceps deliveries were in primipara, approximately 24 per cent of all first cases were instrumental deliveries, while in the multipara the percentage drops to 6%, most of these due to uterine inertia or a very large child. Although this seems like a large percentage of forceps deliveries, yet it is less than the series referred to above.

VERSION.—Version was done twenty-three times, or in 3 per cent. Always for posterior position, eclampsia or transverse position. The more I do this operation, the more favorably I am impressed with it. If properly done at the right time it is a safer and easier procedure than high forceps, and for occiput posterior and transverse positions the choice lies between version and abdominal section and it seems to me in the vast majority of cases, version is much the safer of the two.

CESAREAN SECTIONS.—There are no cesarean sections in this list, but as I look back over these cases I find three cases where abdominal section would probably have been better than the methods used. One forceps and two versions, all three mothers survived but all three babies were lost.

ECLAMPSIA.—Eclampsia occurred five times, two of my own cases and three consultation cases. One, an Austrian wo-

man who was moribund when brought into the hospital, another a neglected primipara twenty-three years old, very fat. When I first saw her at eight months I found her very edematous all over the body, urine scant and loaded with albumen, constant headaches, blurred vision, blood pressure 190. In spite of the most vigorous eliminative treatment she went into postpartum convulsions and died. These two mothers succumbed, both babies survived. Of the other three cases both mother and baby lived, making a maternal mortality of 40 per cent and no infantile mortality.

The Austrian woman probably could have been saved by proper treatment, but the other might have died sooner or later from a chronic Bright's disease. Of these babies two were delivered by version and three with the forceps. I have never induced premature labor and have never been tempted to, but once, after losing a very large baby in delivering with forceps, I was called to care for this same woman during her second gestation and delivery, and, by dieting the mother, I was able to deliver a living child with the forceps at term, which was so thin that he looked like a cadaver, but developed and came out all right when he had more room to develop than in the uterus. I might have saved the first child by inducing labor before term or by abdominal section.

INVERTED UTERUS.—There was one case of inverted uterus in this series. A small primipara, 29 years old, after a night of hard labor pains was delivered with forceps with little difficulty, uneventful third stage, and she left the delivery room apparently in good condition. In about one-half hour the nurse reported her in bad condition. Upon examination it was found that the uterus was partially inverted. Upon consultation we decided to wait before trying to restore the uterus until the patient's condition should improve. She continued to grow worse and died in about two hours, from shock and exhaustion.

PROLAPSE OF CORD.—I lost one baby from

prolapse of cord, the second child of twins. When the water broke, before the engagement of the head, it carried the cord with it and in spite of my frantic efforts to replace the cord, the child was still born and could not be resuscitated.

There have been no cases of thrombophlebitis in this series.

MAMMARY ABSCESS.—There were five cases of mammary abscess, all primipara, and all developed after the patients had passed out of my hands. In two patients both breasts contained abscesses of enormous size.

PUERPERAL SEPSIS.—*There have been* three cases of septicemia. One, an Irish woman, who was infected by the dirty hands of her drunken husband, when I stepped out of the room for a moment. She died. One was evidently infected by unclean pads, as the infection did not show up until the eighth day post partum. She recovered. The third was a breech presentation, in which, after impaction of the breech, I was forced to push the child back and do a version in order to deliver. She made a nice recovery and all three babies lived.

FIBROIDS.—In two cases fibroid tumors of the uterus complicated labor. One was a hospital case, where a large fibroid tumor almost filled the pelvis. Delivered a dead macerated fetus with forceps and afterwards did a hysterectomy, removing the uterus and two fibroids weighing about eight pounds. I reported this case and showed the specimen before the Wyandotte County Medical Society. The other was not so large, but being in the fundus prevented firm contraction of the uterus after forceps delivery, causing severe post partum hemorrhage.

PREMATURE DETACHMENT OF PLACENTA.—I have seen premature detachment of placenta with ante partum hemorrhage in two cases. Both mothers survived but both babies perished.

LACERATIONS OF PERINEUM.—In thirty-eight cases stitches were placed in the perineum, always at the time of delivery. All but one did very well. In this one the

stitches sloughed out, leaving a very bad condition, which the patient still has, as she refused a secondary operation.

SUDDEN DEATHS.—Two young mothers, primipara, died soon after delivery. One, the picture of health, died suddenly about two hours post partum, after a comparatively easy forceps delivery, with no severe hemorrhage. I am still in doubt as to the exact cause of death, although I did a post-mortem I could find no satisfactory cause of death, and so, for want of a definite cause, signed the death certificate "Shock." Whether the anesthetic had anything to do with the death I am unable to say.

POST PARTUM HEMORRHAGE.—Post partum hemorrhage has occurred four times. Once uterine inertia from over-distension of uterus in primipara, with twins; once from fibroid of uterus; once from retained adherent placenta, and once from inertia in a primipara where the forceps was used. All made nice recoveries.

HYDRAMNOS.—Hydramnos has occurred twice. Once only moderate, when the child was born at term and lived; once where the hydramnos was so great that miscarriage took place at six months and the baby died. We collected about four gallons of fluid in buckets, besides what saturated the bed and ran over the floor. Baby died, mother recovered.

DIABETES.—One mother had diabetes and a history of three still born babies before. In this case history repeated itself and the baby was still born at term. Mother recovered her usual health.

Three of my patients had traumatic neuritis following difficult forceps deliveries in primipara. All recovered after much intense suffering; one in about two months, another in six months, and the other suffered more or less for about one year.

FOETAL DEATHS.—Twenty-seven babies have been born dead or died soon after birth, the cause of which was directly dependent upon congenital conditions or accidents at birth. Five were blue babies; one hydramnos; one smothered in the sack, no one being present who knew how to

supture the membranes and release the child. Two died from lead poisoning in the father (my reason for making this statement is the fact that these babies were both from the same mother, the father during this time working in a paint mixing shop and having several attacks of lead colic, but after changing his work two perfectly healthy children have been born to them). One died from prolapse of cord, as before noted; two from congenital deformities, one of the throat and the other from imperforate rectum; three from difficult forceps deliveries; six following version for posterior positions, two of which were dead before version was done and four died while trying to deliver a large aftercoming head; seven were premature. One spina bifida, which I showed at the Northeast Medical Society, and which died after attempted repair of the deformity. One harelip and cleft palate, which had to be fed with the dropper for several months, when the lip was closed by operation, but the cleft has never been fixed. The boy, who was a twin, is now nearly five years old, and with his twin brother, perfectly normal.

SEX OF BABIES.—Contrary to the usual belief and most statistics that there are many more boys than girls born, my records show an excess of girls. There were 765 babies in all; 390 girls and 375 boys.

There were twelve multiple pregnancies, eleven pairs of twins and one set of triplets. Of the twins, in six cases a girl and a boy; in three cases both boys, and in two, both girls. The triplets were one boy and two girls.

Another interesting feature of this series is the fact that of the 727 mothers with living babies, only sixty-two, or about 8½ per cent, could not nurse their babies on the breast. My records are for one month or more, as that was as long as I could keep in touch with many of these mothers. I have also been impressed, while looking over my case reports for this paper, with the very small per cent of the cases that were abnormal in any way, and with the very large per cent absolutely without

complications and which were forgotten until found on the list.

CONCLUSIONS.—Several things have come to me out of my experience which are of considerable value:

First—That we should watch our patients more closely, examine the urine at least once each month and have general supervision of them during the entire period of gestation.

Second—That the danger of infection is very small when proper care is exercised. I have very little fear from the necessary examinations to keep in touch with the progress of labor, or from inserting my hand into the uterus to do a version, or to deliver an adherent placenta, if no one but myself has examined the patient.

Third—That the accidents attending the use of the forceps are due to their improper use without sufficient dilatation or the use of too much force in delivering the head.

Fourth—That after its use in seventy-eight cases without any bad results, save twice where there was hour-glass contraction of the uterus with retained placenta, pituitary extract is a very valuable addition to the obstetrician's outfit, but I am using it now in much smaller doses than formerly. In five to seven minim doses, pituitrin is safe and efficient, and saves many hours of suffering for the patient and of valuable time for the physician without in any way harming either mother or child.

LASTLY—That a man to be a good obstetrician must have working knowledge of gynecology, must keep in close touch with his patient during pregnancy and labor, and interfere as little as possible with the natural course of labor, but be prepared to meet the emergencies that may arise and act with promptness when necessary.

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A Plea for the Earlier Recognition and Elimination of Chronic Infections of the Head

By E. N. ROBERTSON, M.D., Concordia,
Kansas

Read at the Annual Meeting of the Kansas Medical Society,
Ottawa, May 7 and 8, 1919.

So much has been written in our medical journals during the past few years in regard to focal infection that one wonders in starting to consider another article related to this subject if anything worth while can be said. Notwithstanding the increasing number of surgeons and specialists and the abundant literature, medical and otherwise, relating to the direct and indirect effects of chronic infections, there is still much indifference and lack of action among physicians as well as neglect on the part of patients and parents in attending to these conditions, which are known to lead to more or less serious complications.

The specialist is many times criticised for being too enthusiastic in the use of the knife and curet and yet when we consider our own observations over a period of years as well as the case reports of others, one can hardly doubt that in spite of our enthusiasm lives are being sacrificed and patients are continuing to suffer loss of efficiency as a result of the effects of foci of infection which are never eradicated.

It is not my intention to discuss foci of infection other than those ordinarily considered by the eye, ear, nose and throat man, neither will I attempt to enumerate all the local and systemic diseases which our best authorities agree upon as being the direct and indirect result of these buried infections.

In a recent report Dabney* cites the death from endocarditis of four cases, the direct cause of which was tonsillar infection. One of these cases had nothing more serious than a history of repeated attacks of tonsillitis, associated with slight

*1918 Transactions of American Academy of Ophthalmology and Otolaryngology.

pains in the joints. This child died four years after the first examination. Three others died within two years. All of these patients were examined by a competent internist at the time the throat specialist was consulted and none had any heart lesion. In none of the cases was the combined advice of the internist and laryngologist heeded, namely to have the tonsils removed.

Another similar case which occurred in our own practice was that of a child, L. M., age 10, from Nelson, Nebraska. This patient was brought in on account of infected tonsils, in April, 1916. The trouble began with an acute tonsillitis, followed in a few weeks by rheumatism. Tonsillectomy was advised, but refused. After a few months another attack occurred complicated by endocarditis and the child died from this disease in the spring of 1918.

One of the strongest arguments in favor of early recognition of chronic infection of the head is the baneful effect of many such lesions on the eye. I presume the complete history of eye defects caused directly by such infections will never be written. Every oculist can produce records of blind and partially blind eyes the direct cause of which can be traced to a neglected posterior ethmoid or sphenoid infection and the literature of the past ten years is replete with reports of cases of marvelous cures of retrobulbar neuritis and retino-choroiditis by the exenteration of the ethmoid and opening of the sphenoid cavities. Every time it has been my privilege to take care of a case of this kind it has occurred to me, what a pity that this patient has not had some attention to his nose before the eye complication arose. While many of these cases apparently follow a primary acute infection, inspection usually reveals deflected septi nasi, enlarged middle turbinates and even polypi, showing a number of predisposing factors, which if attended to earlier would in most instances have avoided the more serious sinusitis and eye complications.

Less frequently and yet just as certain have tonsils been the cause of eye disease,

although in such cases the involvement is usually more indirect. It is not my desire to weary you with numerous case reports and yet there are several which have impressed me as being unique, and in this connection I wish to cite one where tonsils proved to be a direct exciting cause to a uveitis. E. S., aged 22, the son of one of the prominent physicians of our city, while teaching school in another state, in November, 1914, developed an acute tonsillitis. Before he had recovered from this trouble he noticed that his vision was growing dim and he could not read. He wired home for instructions and was advised by his father to return and was put immediately under my care.

My record shows the following concerning this case: Previous history unimportant, except for an attack of "rheumatic purpura" some years ago. Now complains of a cloud of mist over the eyes. No pain. Inspection reveals injection of ciliary vessels. Iris slightly congested. Atropine instilled. Fine deposits on posterior surface of both corneæ. Fundus examination reveals slight cloudiness of vitreous and perivascular infiltration of retinal vessels. Search was forthwith begun for a possible cause for the serious eye trouble. Teeth were normal. Nose was apparently not at fault. Foul pus could be squeezed from both tonsils which were submerged and as large as English walnuts. Immediate enucleation was advised and done. The next day a decided change in the vision was noted. Instillation of atropine and dionin was the only other treatment used and in the course of ten days the eye symptoms had disappeared, the vision was 20/15 in each eye and the patient returned to his school work. He has never had a recurrence.

Just as we are impressed with the number of cases who present themselves with one blind or partially blind eye, in like manner also do we frequently discover in those who come to us a partial or complete loss of hearing in one ear with or without a history of previous middle ear disease. In so many of these cases do we find a

badly deflected septum or evidence of a past or present chronic infection of one or more sinuses or of the tonsils.

I recall a young lady, L. B., age 16, who was referred to me by Dr. Kimble of Miltonvale, Kansas, a couple of years ago, on account of an aggravated atrophic rhinitis. In addition to her nasal trouble I found a series of complications, such as a partial paralysis of the seventh or facial nerve, epiphora of the right eye, impaired hearing in the right ear and vision 20/100 in the right eye, not materially improved by glasses; the left side of face, eye and ear being normal. The girl was extremely nervous, but otherwise bright and had always made progress in school. Another younger sister as well as an older sister who have been in my office with this patient appeared normal and bright. Could not this train of symptoms be explained along this line: An infection early in childhood of the ethmoid or sphenoid sinuses, which on the right side, extended to the optic nerve causing a retrobulbar neuritis, with consequent permanent impairment of vision? Likewise could not the impaired hearing and facial paralysis have been produced by the infection in the middle ear, undoubtedly an extension from the nose? Can we doubt that this young woman could have in all probability been spared these untoward complications had she fallen into the hands of a competent specialist during the early stage of the nasal trouble?

For a number of years it was my conviction that tonsils in children under five years of age should be respected; that if they had a function, it was probably performed during these first few years. Consequently I have many times during the early years of my practice removed adenoids in young children and left the tonsils and even in a number of cases in children above five, if the parents have objected, I would not insist, unless I could squeeze pus from the tonsils, and would consent to remove the adenoids alone. However, later experience has taught me that where it is possible to demonstrate

a reasonably definite connection between the tonsils and some pathological condition in the child, the tonsils should be removed regardless of the age. I have in mind several of these cases which bear on this point and will relate one or two of them.

One was that of a young girl, Marie A., age 10, a resident of our city who was referred to me by Dr. Weaver in 1910 for an otitis media chronica purulenta. Her parents knew that she had adenoids and desired to have them removed, believing that it would cure the ear. I advised also the enucleation of the tonsils, but this was refused. The ear continued to discharge in spite of the adenoid operation and subsequent treatments until June, 1918, when the young lady was brought back to me to have her tonsils removed. The ear ceased discharging within a week and to my positive knowledge has remained absolutely dry to the present time.

Another case illustrating the value of early tonsil removal in a very young child is the following:

Millard W., age 2 years, was brought to me last summer from Lebanon, Kansas, for a suppurative left ear of a year's duration. The examination revealed a large polypus filling half of the auditory canal. Under ether this was snared out and the base curetted through the opening in the ear drum. A moderately large mass of adenoids was also removed. Tonsils appeared normal and as the parents did not wish them removed I did not insist.

The next day the ear looked clean and the people went home with instructions to care for the ear and report in a short time if the discharge continued or reappeared. About six weeks later they returned with the little patient during my absence, saying that the discharge began again shortly after returning home and wanted to know if it would not be necessary to do a mastoid operation to effect a cure. My assistant, Dr. Lemoine, took charge of the case and strongly advised removing the tonsils in addition to curetting the ear. The parents consented to this and it was done. The following let-

ter received a short time ago, in response to an inquiry, explains the outcome of this case:

"Our boy is just feeling fine. Ear never has bothered him since we brought him home the last time. Don't look like the same boy. We intended to come down but it seems like the roads stay bad so much of the time we just never get there.—G. I. W."

There is a possibility that Dr. Lemoine did a little better job of curetting the ear than I did, but he seems to think that removing the tonsils effected the cure.

While it is a large subject and one which can by no means be adequately covered in connection with this paper, I should like to touch upon the question of sensitization, since it is my conviction that we as physicians and specialists will never succeed in producing altogether satisfactory results until we have a better understanding of the same.

We are all aware that adenoids, diseased tonsils, septal spurs, hypertrophied turbinates and diseased teeth are present in most of these cases and are apparently the chief etiological factors in producing the chronic infections and other complications. We maintain that in all such cases the first thing towards the relief of the infectious process is to get rid of the lymphoid or bony obstructions to drainage. But to perfect the cure and to relieve those who come, in whom complete operations have already been done, or in whom the indications for operation are slight, if at all, we must go into the question of sensitization and determine what are the factors outside of the apparent focal infection which keep patients in such a state of low resistance that drainage and the ordinary remedies at our command fail to produce results.

It is now generally acknowledged that it is a protein poison, so called, whether elaborated by the germs in the hidden focus of infection or produced by some error in diet or through some metabolic process which brings about the state of

sensitization and it is while in this state of susceptibility that attacks of asthma and hay fever are started or our acute colds and infections of the nose and throat begin, followed sooner or later by the complications which we are called upon to treat.

Therefore after we have rendered all possible aid in a mechanical, medical and surgical way and still our patient's resistance to infection does not rise, we should make such further study of the case as will bring about the cause of the relapses.

Every physician can probably cite instances where patients after having faithfully carried out all treatment recommended by their medical advisor, have taken up with some new form of exercise or diet and obtained additional relief which was apparently more permanent than that received from any previous treatment. Others have built up their resistance and overcome infectious processes by living or sleeping out of doors during the greater part of the year. In most cases the resistance may be brought up by an increased and varied amount of nourishing food, while on the other hand one may be kept in a state of sensitization by the ingestion of certain articles of food, for example the case reported by the late Dr. Sawtell,* where a patient kept up a chronic pharyngitis by practically limiting himself to a potato diet, who was cured as soon as other articles of food were substituted for the tubers.

Undoubtedly there are other foci of infection in many cases which are never discovered, which prevent the ultimate good results which we wish to see. In other cases the long years of chronic infection have made such inroads on the vital organs and nervous system of our patients that even after completely eradicating the various foci, the resistance and health can never be brought up to what we desire. Is not this, however, merely another argument for the earlier recognition and elimination of chronic infection?

*Journal of the Kansas Medical Society, February, 1919, p. 25.

Neurasthenia and Associated Psychogenic Disorders

By F. A. CARMICHAEL, M.D.

From the Clinic of the Osawatomie State Hospital

Among the conditions contributing to mental disturbances we have a number of entities closely associated in which the lines of demarcation are poorly differentiated and that merge into one another forming a composite in which there are no clear and distinct lines of separation. This group, known as the psychoneuroses, comprises neurasthenia, hysteria, psychasthenia and, as classified by White, compulsion neurosis, anxiety neurosis and what is termed the psychopathic constitution. I feel that in a discussion of these entities the three latter may be justly omitted as being entirely symptomatic, and particularly the compulsions and anxiety states. The psychopathic constitution may be recognized only as a potential factor relating to all the preceding.

In discussing these states it is not my intention to adhere to the text book classification, but more particularly to present personal views of these so-called episodic conditions and their relation to varied mental disturbances and in their relation one to another.

In discussing the subject of neurasthenia we recognize that we are dealing with intangible factors that produce in the individual certain vague though perceptible mental deviations from the normal. A consideration of a definition of neurasthenia shows that our conception of this morbid condition is not entirely clear, the definition being based upon the two most prominent symptoms manifested, namely, weakness and irritability. This weakness and irritability is both mental and physical and results in an introspective attitude, hypochondriasis and the feeling of physical abnormality and inadequacy. In fact the term "insufficiency" is perhaps more applicable in these cases than in others in which it is commonly employed. From the standpoint of symptomatology several types are recognized such as

cerebrospinal, gastropathic or angiopathic; these terms are purely generic, referring to the visceral point of contemplation, and may not be regarded as separate or definite types in any way.

From our present knowledge the etiologic factors commonly given are misleading and valueless, the condition being attributed either to traumatic or idiopathic causes. It is difficult to harmonize these etiological factors with the numerous conditions existing in cases coming under our observation in this hospital. Traumatism either singly or cumulative has not been a factor and in this statement it is understood that psychic as well as physical trauma is included. The theory that strenuous social life, lack of goal ideas and lack of vivid aims in life on the part of some may possibly be regarded as a factor, however, the development of neuroses of this type is so frequently noted in those in whom the factors of idleness, social overstrain, strenuous mental or physical activity begetting exhaustion, etc., are absent, that we are constrained to believe that the etiology must be sought in other fields and that the key to the situation in practically all instances is found in a potential neurotic mental makeup.

Perhaps the most potent factor in the induction of mental states of this type is an introspective critical survey and re-survey on the part of the individual of certain physical discomforts negligible in themselves but magnified by constant introspective analysis until they are the primary source of persistent mild delusional features, always presenting a somatopsychic tinge leading ultimately to hypochondriasis and a fixed attitude of mental and physical invalidism. It is usually characteristic of these cases that they are of long duration, of gradual onset that even members of the family are aware of certain neurotic characteristics existing prior to the development of the more permanent disturbances.

The dividing line between neurasthenia, hysteria and psychasthenia is based upon certain differential symptoms thought to

exist in one and not found to be present in another. However, in surveying the entire complex we find that the symptoms of one may be found in another in most instances in varying degrees of intensity and the prominence given to symptoms depending upon their intensity constitutes the basis for differentiation between these three associated morbid entities.

It is not regarded as expedient to enter into a consideration of the variation in degree of various symptoms present in these cases upon which differentiation is based, but in the opinion of the writer in all cases of neurasthenia certain hysterical and psychasthenic factors exist as potentials and upon this neuropathic constitution the foundation of these psychoses is reared, the ultimate classification depending to some extent upon the environmental provocation and the ultimate classification upon the preponderance of two or three prominent symptoms which are regarded, at the present time, as differential diagnostic factors.

From the beginning of this paper it would appear the intent of the writer was to present the entire triad under a single heading or to assume that a certain blanket symptomatology is applicable to the entire syndrome, and while this is true to a certain extent it is found impossible to so classify them inasmuch as the method and effect of treatment in each case as well as the course and general reaction of the individual is entirely different; therefore it will be best to attempt, for the present at least, to adhere in some measure to the old classification for greater clarity in considering the differential symptomatology that must be recognized as existing to a greater or less degree in all cases depending upon the predominance of one or the other prominent symptoms.

Inasmuch as it is impossible to consider in the scope of our discussion the collateral opinions of other neurologists and alienists and so far as our ability to determine is concerned, there is very little radical difference of opinion at the pres-

ent time, many factors that may be regarded as essential and clarifying may be profitably omitted inasmuch as they are conflicting, obscure and for the most part purely conjectural. We must recognize primarily from an etiologic standpoint distinct neuropathic conditions capable of producing distinct psychogenic disorders.

Secondly, a gradual developing morbid introspective attitude centered upon imaginary ailments and giving definite reactions characterized by somatic complaints not supported by careful physical examination, impairment of attention, marked weakening of the will, emotional changes, some slight degree of ethical blunting, some impairment of attention, some impairment in the sense of personal pride and an unacknowledged though patent disposition to glory in the mental and physical weaknesses present.

In the neurasthenias of the simple type we have as distinctive characteristics the factors of weakness and irritability with somatic complaints, usually unsupported by physical findings. In the neurasthenias developing psychiatric importance or extending to the point where actual mental impairment develops, the type in which we are particularly interested, we have added to the picture representing simple neurasthenia a wide and varied symptomatology involving characteristics found both in hysteria and psychasthenia.

We are not so much interested in drawing a close distinction between these three groups as we are in definitely establishing differential features that separate them from other conditions that in their early inception may closely simulate the beginning of any mental disease resembling neurasthenia. Paresis, dementia præcox, and the manic depressive states not infrequently are ushered in by an exhibition of nervous exhaustion and mental irritability strongly suggesting this condition.

However, the presence of a mental state based upon somatic complaints that may be definitely determined as of purely psychogenic origin with complaints of weakness, inadequacy, hypochondriasis, emo-

tional alterations, somewhat impaired attention, fatigueability and marked impairment of will, if these be continued over a considerable period, are strongly suggestive of neurasthenia. If added to these we find suggestibility, certain hysterical stigmata either physical or mental or both, with angioneurotic phenomena, the concept should be broadened to include these factors that are hysterogenic, as on the other hand pronounced pessimism, introspective attitude, incapable of being diverted, with the introduction of phobias and obsessions in the presence of unimpaired or only slightly impaired general intelligence it may readily be seen that the mental complex may be broadened to accept the last which we believe should be the primary factor in this associated triad, viz., psychasthenia.

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Excerpts—By The Prodigal

WHERE TO LOCATE—TO THE YOUNG DOCTOR

A doctor should locate where the people are and where the money is. Having prepared himself properly for his work, he has self-confidence (not over-confidence) in himself and knows what he can do and what he can depend on in an emergency. He has no fear in that respect and is removed from the class of the fearful and vacillating. He should select a place where he would like to live—a community with surroundings congenial to his nature. and then dig in.

TO THE OLDER DOCTOR—"SHOULD I CHANGE MY LOCATION?"

It all depends. It is like the answer to whether the word "trousers" is singular or plural. It all depends. "If a man has got a pair of trousers it's plural, but if a man has not got a pair of trousers—why, it's singular." If you have a location that suits you and you are satisfied, let well enough alone. If, however, you have reached the zenith of your practice as shown by your income the past few years, and you are continually obsessed with a normal idea that you can do better and

more for yourself and your family by locating in a larger field, think it over carefully before you make the change, but avoid the advice of fool friends.

Let the measure of your success in opposition to your enemies be a determining factor in making a change. Probably competitors would be a smoother word to use than enemies. Having had several years in the general practice of medicine and surgery you will be able to trail along pretty close to the general practice and keep in touch with it if you take up a specialty. During these years of your general practice you will have learned the special line of work you like best and take to naturally and to which you are adapted.

Push this adaptability to the limit at home and abroad. No, not in Germany but in one of our live American cities, remembering that it is not so much in knowing a whole lot as in knowing a little and how to use it that counts. And if you have the stuff in you, you will be prepared to follow the advice given the young doctor, knowing that what headway you make must be against opposition.

It will be necessary to have a few Liberty Bonds also as standpatters, for a man can't live on gravity.

If you are over sixty years of age and are making a good living, stay where you are. At sixty years of age a doctor should be in his prime. His mind has matured; he is rich in experience; the virility of his physical body is in abeyance. His mind is more nearly stabilized and he sees life as it is. But he should stay where he is. His association, his habits, his physical enjoyments, in fact his whole environment has become woven into the warp and woof of his being and he would be an exceptional man if he could accommodate himself to a new field of work and be content or as useful as where he now is located.

THE DOCTOR—MILITARY AND CIVIL

The military doctor is an autocrat. An autocrat is a sovereign, a despot over his subject. The military surgeon has abso-

lute control over the life of the sick soldier. From a military point of view this power or control is necessary. The training of the military surgeon has been along the line of autocracy. This is of necessity because of the use to be made of him. His preparation is for the work of Sheol—war. It is the duty of the military doctor to keep the vital machinery in order and to repair all injury to the mechanism. To be a real doctor a man must be a dual man. He must be sympathetic and brutish. He must be alive to the refined sensibility of humanity and dead to their sufferings and pain. A military surgeon is an accentuated private doctor in discipline. It takes a superman to be an ideal military surgeon. It is true that man can not realize his ideals, but he can idealize the real. Few men are by nature and art fitted and can measure up to the standard of requirements of such an one. Perfection is almost a meaningless word, as yet. An inkling of it is reported to have characterized the Gallilean. But the stress of His work was on the moral, spiritual and sympathetic, more particularly than upon the autocratic and physical side of man. The real military surgeon is an attractive personality. He is a pattern to be fashioned after in neatness, cleanliness, order, punctuality, and self control. He simulates perfection in motion and bearing. He is truthful and reticent, with a modest reserve born of stored facts and wisdom to use them. Buoyant in spirit, hopeful, an optimist. There is an atmospheric charm in his presence, especially to the sick, maimed and halt. His erudition is in keeping with his commanding presence and his art is perfected by diligence and incessant application to his work. Firmness and fairness mark his every feature and act. He has initiative and is a typical evolutionist. Progress is his shibboleth. The world cannot do without him until creative intelligence fashions a superior hand, out of Adamic clay. What a lesson and living example to the young civilian physician who met up with such a military surgeon in the world war. He

will be better prepared to do private practice on his return home by having had such an association. He will be punctuality, thoroughness and discipline itself. His civil practice before and after such an experience will prevent an atmospheric odor and trait that sometimes develops in the pseudo-military surgeon and offends the olfactory and optic sense of the civil profession and the laity. And in the final judgment of mankind "If it be nobler to restore life than to take it; to relieve pain than to cause it; to avert suffering than to inflict it, then surely the doctor is nobler than the warrior."

LACKING

Lacking is being deficient or wanting. Knowledge and wisdom is deficient or wanting in the successful treatment of pneumonia. Nothing has been accomplished in the drug treatment of this disease. The same may be said of influenza and tuberculosis. Discovering the bug which is supposed to cause the disease has not helped in the drug treatment of it. It has pointed out the disease nest of the enemy, supposedly, and in this it is hoped the range has been found. If it proves to be true the drug shrapnel will get into its work.

Treatment thus far is nil—worse than nil. By treatment is meant the use of lethal drugs to kill the organism that is supposed to cause pneumonia or tuberculosis. These are facts the medical profession is up against. The doctors all know it but a number of them do not practice it. Of the number of reports from hospitals, note the following one by Dr. Fell in the J. A. M. A.: "During the recent epidemic approximately 2,500 cases of influenza were treated in the Walter Reed General Hospital. In 435 of these cases pneumonia either had developed before admittance to the hospital or were diagnosed here during the course of the influenza.

The number of deaths from pneumonia was 226, making the death rate 52 per cent. This includes practically all deaths from influenza and gives a mortality rate

of about 9 per cent for all influenza cases admitted." Dr. Fell is to be congratulated for his frankness and his bravery in publishing the report. Knowing our own failures and acknowledging them to ourselves and to the profession is the beginning of medical wisdom. The weak link in the chain determines the strength of the chain and it must be known before a man can protect and strengthen it. One of the weak links in the medical chain is the treatment of pneumonia. Fifty-two patients out of each hundred cases died. They were treated. The lesson to be learned from such reports is to avoid treatment in cases of pneumonia. Let the patient alone. Give him a chance. The wise thing to do is not to do. Then what? Nurse the patient. Hygiene him. Psychologize him. Feed him. But in the name of Kaiser Bill and that other fellow, don't treat him.

DYSENTERY AND IPECAC

In the latter part of June, 1882, I was called to a case of acute dysentery in a man forty years of age—a farmer—strong and plethoric. The constitutional symptoms were marked, the pain and tenesmus severe with frequent small bloody stools. He was given a cathartic followed by quinine, bismuth, Dover powder and ipecac alternating. He was partially relieved of pain, frequency of stools and fever by the next day. But the third day the fever came up, the local symptoms increased in severity and I was called to see him in the evening of that day and found him a very sick man. Stools frequent, bloody, scant, and pain and tenesmus distressing. Being at my wits' end and having an ounce of pulverized ipecac root in my saddle bags, I sat by my patient four hours by the watch and gave him ipecac every fifteen minutes. If the dose nauseated him a little the next one was lessened and the next one increased. The sixth dose showed beginning relief and at the sixteenth dose there was entire comfort. He had taken one-half ounce of pulverized ipecac root and nothing else in a little water in the four hours. Five-grain doses of ipecac

were left for him to take one every two hours when awake. Ten of these doses were taken. We visited him once more. He made a quick recovery. He had been cinchonized in the beginning of his sickness due to the periodicity of seemingly all sickness in Southern Kansas at that time. I suppose that this was a case of amæbic dysentery. We had no more idea of the cause of the disease at that time than a goat. We hit wildly and in the dark, the same as the flu is known and treated now.

CALOMEL AND DYSENTERY

In July, 1883, I was called to see a patient who was suffering with acute dysentery. Female, 30 years old, in fair health previous to this sickness. It was the usual history of an attack of acute dysentery with frequent small, bloody stools, tenesmus, fever and pain, of some four days' duration with periodicity. She was given quinine—a 00 capsule filled with bismuth (I supposed), with a small quantity of Dover's powder and ipecac. The quinine and bismuth doses alternating every two hours until symptoms of cinchonism, and the bismuth, Dover's powder and ipecac until pain and tenesmus ceased. I called the next morning (twenty-four hours after first call) and found her free of fever, skin cool and moist and the patient comfortable. She was on the bed pan and waiting some five minutes or more I asked her if she did not want the bed pan removed. She said, "No, the water comes from me all the time, not the urine." I caught on. The druggist had filled my calomel bottle with bismuth and the bismuth bottle with calomel and I had done the rest. She had taken three 00 capsules full of calomel minus the Dover's powder and ipecac in them—fully ninety grains of calomel, with the result of freedom from fever, pain and tenesmus, with paralyzed rectal muscle and may be gut and water exuding from the mucous membrane of the alimentary tract like an infant druling. Opium and bismuth was substituted and I went on my way in doubt and trembling, wishing that I had

remained a pedagogue. About midnight the call came to see her. The messenger only knew that she had "stomach pain." It was six long miles of misery for me to her home. I found a lump in her stomach the size of a child's head. She was hungry and had been given two quarts of milk during my fourteen hours' absence and the stomach had been so weakened that it could only curd but not digest the curded milk. It was now 2 A.M. I gave her a teaspoonful of pulverized pepsin, put out a few more doses to be given each hour and went to bed, telling them to call me if needed. I was not needed and awoke at 8 A.M. to find the lump gone and the patient well except weak—very weak—and the flow of water had ceased. Recovery was rapid. A little pepsin was given to help the stomach do its work. The patient made a quick recovery.

In the afternoon of the same day I was called to see the foregoing reported case, I was called to see a case of colitis in a boy three years old, about four miles west of Columbus, Kansas. I gave him the bismuth (calomel) and sugar—some twenty to thirty grains, having the parents repeat the dose in an hour. The first dose quieted the patient and but one dose more was given. As soon as I got home the next morning from the case reported and not hearing from the parents of the boy, some eighteen hours since giving the bismuth (calomel) and having learned my mistake, I made a flying visit to the boy. My depression, however, was not so marked but it was with ill concealed boldness that I knocked at the door of the parents' home and when the door was open and I saw the boy sitting in the bed and playing with some toys, my joy, if confined, was unalloyed, and the smiling countenances looked good to me. There was no prolonged or untoward effect. On inquiry the father said that about an hour after the second dose the discharge from the bowel was so great he hardly knew which to throw away and there had been no pain or discharge since. There was no further medication. It was a fortunate

ending. It did the work and I had learned by accidental experience not to have a dread of big doses of calomel in dysentery and colitis, that ipecac and calomel in those acute bowel troubles are dependable remedial agents, and that a druggist, or the man who is employed by him who is subject to delirium tremens, is not a safe man to put up medicine or a prescription.

THE HUMAN MALE

What is to become of him—that is a part of him? The tendency of the age is to do away with the majority of the male. So many are not necessary for the propagation of the species. This has been demonstrated in raising fine stock. In brute animals eugenics is stressed. Nature's hand is too lavish and man is too lavish, and man (more particularly woman) is asserting rights of umpire.

In cattle the unlike and unpromising are hurried off to the shambles. The horses are gelded, the cockerels caponized, the tomcats emasculated, and the men sterilized.

For the last quarter of a century The Prodigal has urged that all confirmed criminals, all rapists, idiots, imbeciles, and all men who commit murder in a passion should be sterilized. The human male will be saved if he jogs along in this century, makes good and gets somewhere in reasonable time. But he must make good or meet his fate.

—————R—————

Fables for the Kansas Doctor

By RENNIG ADE

Once upon a time there was a Kansas doctor whose wife and daughter decided he needed a vacation.

They would drive through to Colorado in their car and spend a month in the mountains, where it is so cool you have to sleep under blankets.

Quite a number of their friends had been going for several years, and in their vivid letters describing the trip they always mentioned, along with Pike's Peak and the Cave of the Winds, the startling fact that they slept under blankets. The natural deduc-

tion would be that a winter trip to Alaska would drive these people crazy with joy.

The doctor, who was quite a wag and rather cramped financially, suggested that they rent a room in the ice-house down by the creamery, lay in a supply of blankets, and have a hilarious outing without so much expense. Under the rebuking eye of his wife he withdrew these suggestions, and mildly inquired regarding their plans.

Daughter Anna thought it would be just grand to drive through, and stop and camp just when they wanted to, and lead a regular gypsy life. Robert, the 12-year-old son, was also strong for this plan, and became quite a nuisance. Mother as usual was a non-combatant, but was anxious to please the children. The question of suitable milk for the baby, one year old, was settled by Anna, who said they would be going through a great cow country all the way.

The man at the garage looked the car over and allowed that by putting in a new differential and re-lining the brake the old thing would make it. This with two new tires would cost \$124. The railroad fare would have been \$60.

The doctor's competitor, Dr. Frost, told him he would like to get away too, but was just too busy. He also told this freely about town. Mrs. Slinger's annual confinement was due within the next three months some time (she never was within any closer proximity to the date,) and naturally her husband was very indignant that a man would go traipsing around the country at this time. The doctor had not been away from his practice for four years before.

After considerable delay, the car was finally fixed up, loaded up, and the start was made at 8:30 one July morning. Many things were taken that should have been left at home. Sister's guitar was not a traveling essential, neither was Robert's baseball mask and glove, but they had to be taken somehow. Fortunately Dad dropped the thermos bottle and broke it just as they started, so that relieved the situation some. He also forgot the mud-chains in the excitement of getting away, and only found it out when stuck in an irrigation ditch west

of Garden City. This oversight cost him three dollars, which was the price charged by a bronzed leather-colored native for pulling him out with an old team of mules.

Everything went fairly well the first day until 2 p. m., when a series of two punctures and a blow-out—eleven miles from the nearest tree, and with a hot wind with a 105 degree temperature as an accompaniment—rather upset the equilibrium of the journey. The old casing was rusted to the rim, but finally came off along with most of the skin off Dad's knuckles. Also the jack slipped and let the rim down on Robert's foot. Mother said it looked like carelessness on somebody's part. Anna told Robert to stop his howling, which he did as soon as the baby woke up and started his. The pump would not work, so it was necessary to wait for another car, which came along in about an hour. The tire was pumped up and the journey resumed, but the atmosphere of sociability was somewhat clouded for the day.

A camping place was selected near a grove of trees, as a near-by well promised the necessary water for cooking and bathing. After ransacking all the suit-cases, boxes, etc., enough cooking utensils were found with which to prepare supper. Dad built the fire, Robert went after water, Mother peeled the potatoes, Anna combed her hair and powdered her face, and the baby ate all the little red ants he could catch on his blanket. They were all ravenously hungry. The food tasted excellent with the exception of the lemonade. Something was wrong with the lemonade. This question was solved by Robert after supper when he went to the well for dish-water. On this trip he found the inflated remains of two rabbits, a meadow-lark and quite a number of toads, which he vividly described to his mother and Anna.

The next morning they drove twenty-five miles and got breakfast in a hot unsavory restaurant where the proprietor, who was near-sighted, had to scare the flies off the pies in order to distinguish between raisin and custard.

By driving late and early, they managed

to strike enough Harvey eating houses to keep alive until they got to Colorado Springs. Baby had consumed two gallons of sour milk and six boxes of graham crackers, besides a small can of hard oil he had found the second day out, and was in surprisingly good flesh. Mother and Anna's faces were blistered and they looked like the pictures in the Sunday daily entitled, "Walking From Coast to Coast." Robert's foot was so he could almost get his shoe on, and he could drive the car once in a while. Dad's face had not felt a razor since leaving home, his lips were sun-cracked and bled when he tried to laugh at one of his own jokes, which now were very infrequent, and he gazed straight ahead in a sort of grim stoicism. He fed himself and his family in a mechanical way, crawled in behind his wheel, grimly shouted "Contact," and wheezed away. He mentally cursed the big cars owned by the oil men from Oklahoma which crowded him into the ditch and went by at sixty miles an hour.

To make a long story short, they finally arrived in Colorado Springs, a large village in the edge of the Rockies inhabited by people from Tulsa, Oklahoma—and proud of it. They rented a two-room shack at \$65 per month of a positive-looking Amazon who was very careful about the lights being turned off early, and who investigated in case the toilet was flushed oftener than four times in twenty-four hours, her excuse being that everything costs so much out here.

The cottage next to them was occupied by a man and his wife and six children from Meade County, Kansas, who were thoroughly enjoying themselves and insisted on telling about all their trips. On the other side was a cadaverous individual who leaned on the fence and coughed a great deal, and whose wife sponged ten dollars worth of medical advice from Dad every day.

They drank iron-water until they rusted out their bearings, they drank soda-water until they felt like dirigible balloons, they heard the band play, and they climbed

Pike's Peak, but best of all they slept under blankets.

MORAL—If you're looking for trouble you won't need a lantern.

—————R—————

Government Aid Asked for Research in Influenza

At the recent meeting of the American Medical Association, several sections passed resolutions asking for the appropriation of \$1,500,000 by the government to be used for the purpose of carrying on an investigation on influenza, its cause, prevention and treatment.

The following are the resolutions that were adopted by the Section on Industrial Medicine and Surgery:

Whereas, the present influenza epidemic caused approximately 500,000 deaths in the United States, and

Whereas, a large proportion of these deaths were produced by pneumonia and other complications, and

Whereas, influenza, pneumonia, and allied diseases now cause approximately one-tenth of all the deaths in the United States, and

Whereas, medical science is not yet in possession of complete data as to the cause, modes of transmission, prevention, and cure of this disease and its complications, and

Whereas, the possession of this knowledge is of grave social and economic concern to the nation:

Therefore be it resolved, that it is the sense of the members of the section on Industrial Medicine and Surgery of the American Medical Association, here assembled to discuss influenza, that Congress should and is hereby urged to appropriate not less than \$1,500,000 to be used under the direction of the U. S. Public Health Service for the investigation of the causes, modes of transmission, prevention and cure of influenza, pneumonia, and allied diseases, this sum to be made available to July 1, 1922.

Transmitted by order of the session, held in Atlantic City, June 13, 1919.

DR. OTTO P. GEIER, Secretary.

THE JOURNAL

of the

Kansas Medical Society

W. E. McVEY, M.D. - - Editor

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Our Library

Someone recently suggested that the Society had apparently forgotten that it had any interest in the Stormont Library. It has been a good many years since a report on the condition or needs of the library has been submitted to the Society. The library is still in the Capitol building, accessions are still being made to it, and it now contains something over 6,000 volumes.

A considerable number of periodicals are regularly received. It is a very excellent library, but the profession has so far not availed itself of its advantages to any considerable extent. A very few physicians ever visit the library and still fewer make any attempt to utilize its resources. Even the physicians of Topeka seem to have forgotten that the best medical library in the west is so convenient to their hands.

Naturally those who have charge of it feel that time and money are wasted in trying to build up and maintain a library, when those for whom it was established make no use of it.

Some years ago, in order that it might be of more service to physicians throughout the state, it was arranged that books

could be taken from the library and could even be sent to physicians in other parts of the state, but even this did not greatly increase the demand upon its resources.

At another time it was suggested that a larger and better selection of medical periodicals should be kept on hand, and a considerable list of periodicals was made up. Although these have been kept on file, a very small number of physicians consult them.

In so far as books go to make up a library the Stormont Library may at this time be regarded as the best medical library in the west. The most valuable medical library of this period, however, is not made up of books alone. The most valuable library for consultation and for reference is a large collection of the best periodicals, which has been carefully card indexed and properly filed. This, of course, means a considerable amount of work on the part of someone who is competent and painstaking, and sufficiently interested to make the indexing complete. A very excellent library of this kind will be found in the Clinical School at Rosedale.

We suggest that a committee be appointed from the State Society to revise the list of medical periodicals for the Stormont Library and arrange for its proper indexing. If this cannot be done with the funds available from the endowment fund of the library we suggest that the expense be carried by the State Society.

We suggest also that some means be provided by which the physicians of the state may know what books are available at the library, that a catalogue be published and distributed among the physicians of the state, with full information.

—R—

Prevent Recurrence of Epidemic Influenza.

One of the most vital problems now before the medical profession and particularly the health authorities is how to prevent a recurrence of epidemic influenza. Fortunately for the people the public health authorities are not wasting much time in discussions as to the best methods,

but are going right ahead, making arrangements to carry out a plan of campaign that it is hoped will control every source of infection. The fact that we do not know how the disease is transmitted from one person to another or from one community to another is not sufficient reason to abandon all efforts at prevention. It is the general consensus of opinion that the disease is transmitted by contact, and quarantine is certainly the method of control to be adopted. No one can deny that even the imperfect quarantine regulations of last year showed sufficient effects upon the spread of the disease to justify the enforcement of more rigid measures. The efficiency of rigid quarantine was more definitely shown in public institutions where large numbers of people were confined, but where adequate quarantine measures could be thoroughly enforced.

According to the reports of the experiments conducted by the U. S. Public Health Service the theory that the disease is transmitted by the secretions from those in the acute stage of the disease seems to be controverted, but it is not safe to put too much confidence in negative results. In the present state of our knowledge, the possibility of this mode of infection should not be ignored and the health authorities are acting wisely in requiring the sterilization of all utensils in public drinking places.

The fact that we have so little definite knowledge of the course of the disease and its transmission seems rather to justify a multiplicity of preventive measures in the hope that some of them may prove efficient.

—————R—————

The Council on Pharmacy and Chemistry.

If one will compare the medical journals of a dozen years ago with those of today he will be struck with the very great difference in the character of the advertising. There was a time when the advertising manager of a journal never questioned the merits of the preparation advertised. He was satisfied, as he thought, to let the advertiser bear the blame for any mis-

representations that might be made. No publication can, however, shift the responsibility for the statements that appear in its pages.

The profession should recognize that the most important factor in the clearing up of the advertising pages of medical journals has been the Council on Pharmacy and Chemistry of the American Medical Association.

The Council has been criticized by both the manufacturers and the profession, but it has gone on patiently and persistently doing the work for which it was created.

Manufacturers sometimes feel agrieved because they are prevented from exploiting a worthless preparation through the advertising pages of the State Journals. Occasionally one who honestly believes he has a preparation with therapeutic merit feels agrieved because the council fails to find that the claims made for it are justified by the composition of the preparation and what is known of the physiologic action of its ingredients.

Sometimes a practitioner feels that his clinical experience justifies the use of a preparation which the council has not found reason to approve. While apparent clinical results may be misinterpreted, the carefully conducted chemical examinations and therapeutic tests conducted by the Council are likely to be definite and dependable.

The claims, advanced by manufacturers for the therapeutic effects of their preparations, are very frequently based upon the reports of clinical results obtained by various individuals. We are becoming more and more thoroughly convinced of the unreliability of such evidence.

While there is no doubt that the work of the council is appreciated by the profession, it is quite evident that it does not avail itself of all the benefits that it might derive from that source.

If practitioners would consult the regular reports of the council, if they would keep on hand a copy of the "New and Nonofficial Remedies" for ready reference and prescribe only, of the new prepara-

tions, those that have been approved by the council, they would aid very materially in establishing a reliable and scientific therapeutics.

—R—

A New Ruling on Narcotics

The following new regulation in regard to prescribing narcotics for addicts has recently been mailed to members of the profession by the Collector of Internal Revenue for this district.

"The ruling contained in T. D. 2200 of May 11, 1915, permitted a practitioner to dispense or prescribe narcotic drugs in a quantity more than is necessary to meet the immediate needs of a patient is hereby revoked and the revocation shall be applicable in all cases whether a decreasing dosage is indicated or not.

"The Act of December 17, 1914, as amended by the Act of February 24, 1919, permits the furnishing of narcotic drugs by means of prescriptions issued by a practitioner for legitimate medical uses, but the Supreme Court has held that an order for morphine issued to an habitual user thereof, not in the course of professional treatment in an attempted cure of the habit, but for the purpose of providing the user with morphine sufficient to keep him comfortable by maintaining his customary use, is not a prescription within the meaning and intent of the Act U. S. v. Doremus, No. 367, October Term 1918, T. D. 2809.

"In view of this decision, the writer of such an order, the druggist who fills it and a person obtaining drugs thereunder, will all be regarded as guilty of violating the law.

—R—

We are still having some difficulty in locating the members who have been in the army. If the Secretaries will send to this office a list of their members who have been released from service with their present addresses it will be very much appreciated.

—R—

The American Red Cross has appropriated \$65,000 to enable the American Wo-

men's Hospital Association to send a mobile hospital unit to Serbia for relief work in connection with typhus and other epidemics. Of this amount, \$25,000 is a cash donation, the balance representing supplies to be provided from existing stocks in Europe.

—R—

Dr. J. F. Hassig, Kansas City, Secretary of the Kansas Medical Society, has finally been released from the army and is again on the job as Secretary.

—R—

A copy of the revised Constitution and By-Laws has been mailed to every member in good standing. If by any chance you failed to receive a copy, please notify this office.

—R—

The Women's Contributions

Surgical dressings to the number of 300,996,071 and valued at \$13,922,292 have been turned out by the volunteer women workers in Red Cross Chapters in the United States during the eighteen months preceding January, 1919. They also produced 29,422,390 hospital garments and supplies, valued at \$26,818,943. The total value of the work of the 8,000,000 women volunteers is placed at \$81,449,997.

—R—

American Doctor Killed in Beirut

Major Edward Kent Armstrong of Cape May, N. J., who has been engaged in relief work for the American Red Cross in the Holy Land, was instantly killed in an automobile accident at Beirut on the night of May 31st, according to a cable message received July 1, at Red Cross Headquarters. He sustained a fractured skull when the car in which he was riding plunged over the side of a thirty-foot culvert.

Major Armstrong, who is well known in Chicago, where he practiced medicine for a number of years, had been in Red Cross service overseas since April, 1918. For several months he was engaged in child welfare work in France, leaving for Palestine last January to take up similar work in that country. He was a graduate

of the University of Illinois and an associate professor of pediatrics at that institution. At one time he was superintendent of the Communicable Disease Hospital at Chicago and attending physician at the children's department of the Cook County Hospital. The cable message says Major Armstrong was buried in the American cemetery at Beirut with full military honors.

—R—

The Southwestern Tuberculosis Conference will be held at the Hotel Virginia, Long Beach, California, October 1-2-3, 1919 under the auspices of the National Tuberculosis Association.

This conference includes the states of Arizona, California, Colorado, Kansas, New Mexico, Oklahoma and Texas, and the purpose of the meeting is to afford the opportunity for an exchange of ideas regarding the various public health and tuberculosis problems encountered in these states and how they can best be met.

This year's officers of the Conference are:

President, Dr. Robert A. Peers, Colfax, California.

Vice-Presidents: Arizona, Dr. Jeremiah Metzger, Tuscon; California, Dr. C. C. Browning, Los Angeles; Colorado, Dr. Gerald B. Webb, Colorado Springs; Kansas, Dr. S. J. Crumbine, Topeka; New Mexico, Mrs. A. Otero-Warren, Santa Fe; Oklahoma, Mr. E. K. Gaylord, Oklahoma City; Texas, Mr. J. D. Harper, Dallas.

Secretary, Mrs. E. L. M. Tate-Thompson, Fresno, California.

Committee on Program and Arrangements: John Tombs, Regional Secretary, National Tuberculosis Association, Albuquerque, New Mexico; Mrs. E. L. M. Tate-Thompson, Executive Secretary, California Tuberculosis Association, Fresno, Cal.; Dwight E. Breed, Executive Secretary, Texas Public Health Association, Austin, Texas.

—R—

Physicians prefer to buy advertised goods, because such goods have standard prices, which prevent profiteering.

SOCIETY NOTES

OSBORNE COUNTY SOCIETY

The Osborne County Medical Society met in the club rooms at Osborne, Kansas with the following members present: Drs. J. E. Hodgson, W. W. Miller, B. F. Chilcott, and S. J. Schwaup. The visiting members were: Drs. S. M. Drennan, Osborne; J. D. Johnson, Alton; and A. M. Richmond, Downs.

The application of Dr. J. D. Johnson was read and he was voted into the society.

Drs. J. E. Hodgson, T. O. Felix, and W. C. Burtch paid their dues for the coming year.

Discussions on topics of interest to the profession and Osborne county doctors were taken up after which the society adjourned to meet at the call of the President and Secretary.

Our member, Dr. E. A. Drake, has returned from service and we expect him back with us at our next meeting.

Dr. S. J. SCHWAUP, Secretary.

HARVEY COUNTY MEDICAL SOCIETY

The Harvey County Medical Society met on the porch of the home of Dr. E. L. Kalbfleisch, after dining together. In spite of the hot weather eighteen physicians were in attendance, the largest number since the war began. A paper by Dr. Kalbfleisch on "End Results of Operations on Breast Cancer" was very interesting and instructive. Dr. V. E. Chesky of Halstead Hospital gave reports of cases having their origin, evidently in infections of the tonsils. Both papers were freely discussed.

FRANK L. ABBEY, Secretary.

HARPER AND SUMNER COUNTY SOCIETIES

The Harper and Sumner County Societies held a joint meeting at Argonia, August 7. The following program was prepared for this meeting:

Pernicious Anemia, by H. L. Galloway.

The Outlook, by J. C. Caldwell.

Bone Abscess, by W. H. Gaume.

Angina Pectoris, by Chas. J. Golden.

Pneumonia Next Winter, by H. A. Vincent.

BOOKS

RECONSTRUCTION THERAPY

By William R. Duntton, Jr., M.D., Assistant Physician at Sheppard and Enoch Pratt Hospital, Towson, Md.; Instructor in Psychiatry, Johns Hopkins University. 12-mo of 236 pages, 30 illustrations. Philadelphia and London: W. B. Saunders Company, 1919. Cloth, \$1.00 net.

Reconstruction therapy has assumed considerable importance in our affairs of life and there is a great field for the application of these principles which have already been worked out. The author shows many of the devices which have been constructed for the aid of the crippled. Great things have been accomplished for those who have lost one or more limbs, and perhaps fully as great things are being done for the deaf and blind. For the man of ordinary intelligence there is hope for an active and productive existence, even with the handicap of any of these misfortunes.

DIET IN HEALTH AND DISEASE

By Julius Friedenwald, M.D., Professor of Gastroenterology in the University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore; and John Ruhrah, M.D., Professor of Diseases of Children in the University of Maryland and College of Physicians and Surgeons, Baltimore. Fifth edition, thoroughly revised and enlarged. Octavo of 919 pages. Philadelphia and London: W. B. Saunders Company, 1919. Cloth, \$6 net.

"Dietetics has always been a subject much influenced by fads and fancies, and much of the literature has little value in consequence." So say the authors in the preface to the fifth volume of this book. There is much that is well established, however, and they have presented the facts that are known as well as the best opinions on matters that are yet to be definitely determined. In the fifth edition some new material has been added; articles on vitamins, amino-acids, acid and alkali contents of food, food allergy, Sippey's diet in peptic ulcer. Many chapters have been entirely rewritten. This edition also contains Locke's "Tables of Food Values."

1918 COLLECTED PAPERS OF THE MAYO CLINIC
Rochester Minn. Octavo of 1196 pages, 442 illustrations. Philadelphia and London: W. B. Saunders Company, 1919. Cloth, \$8.50 net.

The collected papers of the Mayo Clinic

for 1918 has just been received. To attempt a review of each of the papers included in this volume is entirely out of the question. They are all so timely and bear such close relation to the progress of medicine that it is enough to say ones' education is incomplete who fails to read it. No effort is made to cover the whole field of medicine or surgery, but the subjects that are discussed are of vital interest to the medical man and the discussions are all based upon careful research and long continued clinical observation. One of the papers that is of particular interest is by W. J. Mayo on "Civil Surgical Practices Suggested by the War."

The Medical Clinics of North America
May 1919, Index Number. Published bi-monthly by W. B. Saunders Company, Philadelphia and London. Price per year, \$10.

The Medical Clinics of North America—the Baltimore Number—May 1919, contains a clinic by Barker that will appeal to the average medical man. Friedenwald discusses the treatment of ulcer of the stomach and the types of achylia gastrica. Wilson has an article on the treatment of pulmonary tuberculosis. Clough has a clinic on pneumococcus sepsis that is especially instructive. King has some very interesting facts to present in connection with the discussion of intestinal disturbances in metabolic diseases. Hamman discusses the subject of diabetes and also has a clinic on auricular fibrillation. Krause has a very interesting article on multiple tuberculosis in children.

Industrial Communities for Arrested Cases of Tuberculosis

In a study, made under the direction of the Advisory Committee of the National Tuberculosis Association for the Federal Board of Vocational Education, Pattison contributes a comprehensive plan, worked out in great detail, for the establishment of industrial and agricultural colonies for arrested cases of tuberculosis. The paper is very complete in that the reports of various committees, the views of authorities and the opinions of patients are cited,

while one of three appendices goes into the probable maximum amount required as subsistence aid during one year for a given number of tuberculous persons and their families.

Pattison states that the basic idea of the colony plan is the development of industries around a community for the sake of that community. He describes the ideal site for such a village which should be laid out according to modern ideas of town planning to care for 500 or 600 population at once, with possibilities for expansion to 4,000. He outlines the proper administrative organization, the various industries and occupations that would be peculiar to such a village, and the properties and developments that may be required. The initial cost for a population of 600 is estimated at \$1,643,698, while the village could be made to take care of an increase of 100 per cent. of population at an added cost of from \$600,000 to \$800,000. The annual maintenance expense would be about \$60,000, which would be largely offset by rentals and charges. During the first months of residence most families and single persons would not be wholly self-supporting. Some subsistence aid would be required, and the total maximum fund which it is estimated would be needed during the first year is \$56,056.

Pattison, H. A. The Industrial and Agricultural Community for Arrested Cases of Tuberculosis. *American Review of Tuberculosis*, July, 1919, Vol. III, No. 5.

—R—

Effect of the War on the Cancer Death Rate

Commenting on recently published English statistics, Dr. Francis Carter Wood, Director of the George Crocker Special Research Fund of Columbia University, takes occasion again to emphasize how easy it is to be misled in regard to the relative prevalence of cancer in any particular locality unless the age distribution of the population is taken into account. In England and Wales the cancer death rate has shown a decided increase during the war, but this is doubtless due to the

fact that that portion of the male population below the age of 45 has been so largely removed to France and Belgium, so that for the time being the older age groups, in which cancer is naturally much more frequent, have unusual predominance in the population left at home. According to the report of the Registrar General of Great Britain cancer mortality during the war greatly increased among males, while among females little or no change was observed. For the three years preceding the war the cancer death rate among men was 91 per 100,000 of population. In 1916 it had risen to 96 per 100,000, while in 1917 it reached 98 per 100,000. Among women the rate for the same period before the war was 99 per 100,000 and in 1916 it had risen only to 101, while in 1917 it dropped back to 100 per 100,000.

As has been frequently pointed out, variations in the cancer death rate due to the dislocation of classes of the population have long been observed in the United States. Vermont has the highest cancer death rate in this country, the figures reaching 109.9 in 1914, while the rate in Utah was only 45.6. According to Dr. Wood, there is not the slightest reason to suppose that cancer is more frequent among people of the same age in Vermont than in a Western state such as Montana where the 1914 cancer death rate was 51.5. The explanation lies in the fact that in the western states the population is mostly of the pioneer type, whereas in Vermont the present inhabitants are predominantly within the older age groups, the young people having largely emigrated to the industrial centers of other states.

—R—

Kinematic Surgery in Military Hospitals

Remarkable results have been achieved in Italian Military Hospitals recently by the use of what is known as "kinematic surgery" the invention of Professor Putti of Bologna University. Professor Putti's methods have aroused intense interest on the part of American doctors attached to the Balkan Commission of the American Red Cross who are supervising the arti-

ficial leg factories already established and being established in Athens, Salonica, Belgrade and Bucarest for the war's mutilated.

At the present moment the Allied soldiers in the Balkans who have lost their limbs are being fitted with artificial legs and arms of a type similar to that employed by Sarah Bernhardt. Professor Putti's methods, however, are a distinct advance over all other artificial appliances.

His treatment of amputated limbs consists of a unique preparation of the stump to develop a "motor" end to the cords which, after being bound together over a smooth "bearing" of bone, get as much as a three inch travel of the leg by means of a re-education and co-ordination of the muscles of the stump.

After the stump heals, Professor Putti cuts out a flap of flesh which he folds back into an incision to take the flap. This is allowed to heal and then, through the loose flap of flesh, a metal bar with attachments to operate the artificial limb below is suspended.

The muscles of the calf and thigh readily respond after some weeks, to the movement of the artificial leg, and soon the pressure of the swinging of the artificial leg re-educates the muscles through the flap of flesh so that it may be said that the muscles of the stump actually operate by themselves the mechanical features of the artificial limb.

In case of a severed hand, the muscle groups surrounding the bone are trained to operate catgut cords, which in turn, operate artificial fingers. Not since the introduction of "debridement" in American Army medical work in France has any medical innovation created so much comment.

—————R—————

Seasickness.

A. E. Lemon, Sault Ste. Marie, Mich. (Journal A. M. A., July 12, 1919), reports his observations of seasickness on the transport Great Northern on a passage with troupes from Brest to New Yory. His previous sea experience had included some

Newfoundland trips, which were free from this disorder. But the Great Northern had a marked plunging motion, or rise and fall, owing to the light forward ballast and the high speed. There was very little rolling motion. While he had never been seasick before for years, and was not sick at all on the rough trip across in February, 1918, he became very sick as soon as they got out of the Brest harbor. He had been careful to prepare himself for the trip, eliminating diet indiscretions, alcohol and constipation as possible causes. He felt a fine, indefinite change of pressure on the ear drums, for which he could find no cause, and to relieve it packed his ears, without touching the drum, with sterile gauze which gave immediate relief. As 90 per cent, of the troops on board and a considerable number of the crew were seasick, totaling at least 700 individuals, he applied the same remedy as official surgeon of the troops, to those who were still affected. After being relieved for several hours, removal of the packing brought on the symptoms again in some cases. He learned also that soldiers that had been under shell fire were much more liable to seasickness, and surgeons from other transports have told him that almost without exception such men were more affected with seasickness coming back than when going over. His success on this trip with the method used was so immediate and effective that the only possible cause of its failure on other ships would seem to be the unlikely but possible existence of other forms of seasickness.

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Foreign Protein in Pneumonia.

C. W. Wells, Camp Travis Texas (Journal A. M. A., June 21, 1919), reports the results from the intravenous injection of a foreign protein in eleven cases of influenzal pneumonia. Nine of the patients were critically ill, and the prognosis, grave. "The protein used consisted of typhoid bacilli, macerated and exposed to the soluble action of alcohol for twelve hours, washed free of alcohol and suspended in physiologic sodium chlorid solution, the

concentration being the equivalent of approximately three million bacilli per cubic centimeter. The dose employed was sufficient to produce a definite so-called protein reaction, as a rule 1 c.c. Leukocyte counts were made previous to the injections, and from four to twelve hours following the reaction. In several cases blood chemistry determinations were made before and after the injections." Thirty to forty-five minutes after the injections a typical protein reaction occurred, with severe chill and moderate cyanosis, followed by profuse sweating and a marked elevation of temperature. Shortly after this the patient felt decidedly better and seemed improved. In several cases there was a rapid crisis after the fever with no subsequent rise of temperature. Several cases are reported and a table of blood examinations given. Wells also reviews the literature of similar treatment by others. So far as can be determined, the intravenous injections of typhoid protein had no deleterious effect as regards increased retention of the products of catabolism. It is his opinion that the method is efficacious in selected cases, but should not be used as a routine by the general practitioner.

—————R————— **Bacterial Carriers.**

In a survey between January 26, 1919, and May 1, 1919, at the Walter Reed General Hospital, by J. S. Simmons and R. E. Taylor, Takoma Park, D. C. (Journal A. M. A., June 28, 1919), to determine the number of normal persons carrying hemolytic streptococci in the upper respiratory tract, 3,174 persons were examined. This included the entire hospital personnel, all patients in infectious disease wards, and all admitted in the receiving ward. While the streptococcus prevalence was the principal object of the study, pharyngeal cultures were also taken for pneumococcus and meningococcus, and in the last 1,299 cases, for the Klebs-Loeffler bacillus. Their method of taking cultures is described. They used the morphologic appearances, etc., for identification. Of the 3,174 throat cultures made for hemolytic streptococci,

1,774 (56 per cent) were positive. The highest total percentage of carriers was found in the admissions to the receiving ward, and the lowest in the infectious disease group. The results are tabulated, both as to these points and as to the weekly variations. The highest point of the carrier curve occurred April 23, while there was only one case during the whole month of April of streptococcus pneumonia. In sixty-six individuals, who had previously undergone tonsillectomy, six were +, nine were ++, and none were above these, making a total of 22.8 per cent. Twenty-five per cent of the 3,174 throat cultures were positive for pneumococci. Unfortunately, the types were not determined. The infectious disease group gave the largest percentage of these positives (45 per cent), while the receiving ward gave the lowest (20.5 per cent). Ninety-four (2.99 per cent) meningococcus carriers were found among 3,174 nasopharyngeal cultures. Sixty-one of these were normal, thirty were para and four were intermediate types. In forty-one of these positive carriers, none of which were treated, cultures were taken after eight weeks had elapsed, and only three normals and one para were still positive. Eighteen positive cultures of the Klebs-Loeffler bacillus, or 1.4 per cent, were obtained from 1,299 persons examined between March 1 and May 1, 1919. This is approximately the average percentage reported as normal by Goldberger, Williams and Hachtel. A comparison of the weekly percentage of carriers with the weekly occurrence of infection failed to show that any direct relation existed between the two.

—————R————— **Malaria Control.**

C. C. Bass, New Orleans (Journal A. M. A., July 5, 1919), considers the disinfection of the malarial patient is not sufficiently made the object of treatment by the practitioner, who is apt to consider that the disappearance of clinical symptoms and lack of demonstrable parasites in the blood are all-sufficient. No known method of examination can exclude the possibility of

remaining latent infection, and the best we can do is to insure the duration of treatment that experience has shown to be effective. Quinin in sufficient doses, given for a sufficient length of time, is effective in all cases; he sees no exceptions to this. Cases in which the average successful treatment fails simply mean that quinin in those particular cases, and in the particular amount given and time continued, did not suffice, but might still succeed if continued. To make it satisfactory to the patient, the treatment must be practical and not cause serious discomfort. One dose at night is usually more convenient than a number of smaller doses and just as effective. The treatment Bass recommends to completely rid the system of the malaria is 10 grains of quinin sulphate at night for a period of eight weeks, and in some cases still longer. This applies to cases in which acute symptoms have ceased. The acute attack can be relieved in practically all cases by three 10-grain doses of quinin daily for three or four days.

—R—
Myomas.

The operative as opposed to the roentgen-ray treatment of uterine myoma is advocated by Arthur Stein, New York (Journal A. M. A., July 12, 1919). Too much confidence in the benign character of myomas, he says, has induced certain operators to put too much confidence in the possibilities of the roentgen ray in treating these tumors. There is a tendency he thinks, to malignant degeneration, and while he recognizes the difficulty of diagnosis, he thinks that only curettage will enable one to exclude it. In many instances, however, the uterine cavity is entirely obstructed by the tumor, and the curettage test cannot be made or relied on. With experience of the end-results of over 100 cases, he concludes it is not possible to exclude malignancy. The high percentage of malignant cases, moreover, makes delay more dangerous. In a previous article he has warned against starting proliferative malignant changes in those parts of the tumor not destroyed by the ray, and he is

convinced of the superiority of surgery in these cases. He quotes several authorities who agree with him, and holds that the surgical treatment is simple, efficient and safe. In the total of 120 patients, ranging between 23 and 62 years of age, he found serious complications in sixty-one, and there were four deaths, or 3.3 per cent. In his previous contribution, moreover, he referred to intestinal disorders following radiation, as an additional possibility of danger. At best the radiated patient retains her tumor, though the symptoms may be relieved, and his statistics show that about 50 per cent of all myoma cases are complicated by pus-tube, hydrosalpinx, hematosalpinx, acute or sub-acute appendicitis, ectopic pregnancy, etc., and in young women who have not reached the menopause the roentgen ray will bring on a premature cessation of the ovarian function. This is in addition to the disturbance of the intestinal mucosa referred to above. According to his experience, the surgical treatment has only 1 to 3.5 per cent mortality, besides being the most thorough, quickest and most reliable.

—R—
Alternating Periodic Ovarian Swellings.

Emil Ries, Chicago (Journal A. M. A., July 12, 1919), takes up the subject of ovarian swellings, such as those due to a ruptured corpus luteum cyst, and other troubles due to irregularity of that rupture. The type he calls alternating periodic ovarian swelling is one that is disturbing and liable to produce bad feeling among the physicians. The patient goes to one who tells her she has an ovarian cyst on the right side needing operation. After a few days she consults the second one, who assures her she has no tumor at all. Confused, she goes to a third, who examines her and says she has a tumor on the left side. In a case of this kind which came to him, this type was suspected, and he advised against operation. He first described it in 1913, and it has been studied in over a dozen cases since 1906, in three of which he has operated. A number of others were observed in which

the condition was present in a rudimentary way. The three operative cases are reported and the pathologic conditions described. In Case 1 the patient had had thirteen right and seven left swellings, and various pathologic conditions for which the ovaries were removed. He concludes that if a patient with these symptoms has been observed a sufficient length of time to establish the diagnosis and suffers considerably, but for some reason should not be operated on, the intentional rupturing of the cyst gives at least temporary relief. The swelling is due to a pathologic condition as shown by these cases, of the corpus luteum which we are learning to better understand. We now know that the ovary and corpus luteum have special functions. We might compare the female sexual tract with the clock of which the uterus might be the hands and the corpus luteum the pendulum or regulating mechanism. When the latter gets out of order the rhythm becomes disturbed. "It is evident that if we have such a patient with alternating periodic ovarian swellings and see her for the first time and break her cyst under our fingers, we cannot tell what we have broken. But when we are better acquainted with the abnormal periodicity of her ovaries, we can even go so far as to rupture her cyst intentionally and with beneficial results." The doctors in the illustration used were all correct in their diagnosis and it would be well for us to remember this clinical picture before disturbing the patient's confidence or injuring the feelings of our colleagues. An irregularity of the corpus luteum may cause diagnosis of extra-uterine pregnancy, and later symptoms of these alternating ovarian swellings may appear.

—————R—————

Arterial Restitution.

C. C. Guthrie, Pittsburg (Journal A. M. A., July 19, 1919), reports an experiment in which the right common carotid of a female dog was divided, and a segment of vena cava, preserved for sixty days in formaldehyde solution, was interposed between the severed ends. The implanted

tissue was treated with ammonia and absolute alcohol, and impregnated with petrolatum just before the experiment, which was performed, January 22, 1908. On the following February 12, the artery was exposed and examined and showed active circulation through the interposed segment. Clinical examination from time to time demonstrated like pulsations of the two common carotids. The animal raised pups in 1909 and 1910, and remained in excellent condition except after occasional fights with other dogs, until she began generally to decline with old age. Examination shortly after death, which was sudden, on March 20, 1919, revealed the two scars of the previous operation. "There was an enlargement of the right common artery about 3.5 cm. long and 2 cm. in diameter on the course of the artery near the root of the neck, several centimeters distal to the origin of the artery. Above and below, the artery appeared and felt normal. The enlargement was fibrous and vascularized on the surface, and to the touch was resistant, but springy and apparently hollow. A connection through the mass between the two parts of the artery on each side was demonstrated by manipulation under liquid, and confirmed by section." The experiment is of interest as showing that devitalized tissue can take up its function again and keep it up for years, as well as for being the first of its kind.

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Diagnosis of Tuberculosis

Thomas McCrae and E. H. Funk, Philadelphia (Journal A. M. A., July 19, 1919), say that, while the recognition of chronic pulmonary tuberculosis is usually regarded as a simple matter, with small chance for error, this is not always the case, as can be readily seen by men with large experience. The authors report the results of a study of 1,200 consecutive admissions to the Jefferson Hospital, Philadelphia, with the diagnosis of advanced pulmonary tuberculosis. In this series seventy-two, or six per cent, were found to be non-tuberculous, and out of 134 necropsies in

this series, no tuberculosis was found in seven, which is fairly close to the percentage given above. In five or these cases there had been a correct diagnosis made before death. They refer to the work of Ash (The Journal, Jan. 2, 1915, p. 11), who found in 198 necropsy cases, twenty-three nontuberculous, only seven of which had been correctly diagnosed before death. In the authors' own series, "the various conditions which were wrongly diagnosed as advanced pulmonary tuberculosis are: cardiorenal, 19; pneumonic sequelae, 9; bronchiectasis, 8; abscess of lung, 8; chronic bronchitis, 6; neoplasm, 5; syphilis, 4; aneurysm, 2; anthracosis, 2; bronchial asthma, 2; empyema, 2; diabetes mellitus, 1; cancer of rectum, 1; foreign body, 1; malingering, 1." The various disorders mistaken for tuberculosis are described in brief detail. The cardiac cases seem to be wrongly interpreted, partly through carelessness. The chronic inflammatory conditions of the lungs are generally more difficult problems. Six of the nine were typical cases of bronchopneumonia; three were unresolved lobar pneumonia. The influenza epidemic had undoubtedly something to do with the origin of these cases, and most of them came in last winter. Bronchiectasis is easily mistaken for tuberculosis if the sputum is not examined. Sputum examination was evidently neglected in the 8 cases of pulmonary abscess. Sputum, persistently purulent without tubercle bacilli, is strong evidence against tuberculosis. Emphysema and chronic bronchitis were mistaken for it by reading symptoms and signs alone, and the same remarks apply to cases of new growths in the lungs. Syphilis was conservatively diagnosed in the four cases, but seemed thoroughly proved. Aneurysm, bronchial asthma, and empyema may need the roentgen ray to confirm a nontuberculosis diagnosis. Anthracosis is more frequently the cause of mistake than the figures indicate, and many such cases are early recognized in the dispensary and sent to the general wards. Lack of thorough examinations with hasty conclusions and neglect of

sputum examinations are probably the main causes of mistakes. The authors consider that the ordinary six negative sputum examinations in early cases are not enough to exclude tuberculosis. In the apparently advanced cases of tuberculosis, a diagnosis without positive sputum examinations should never be made, and physicians in tuberculosis hospitals should give particular attention to this point.

—R—

Varicose Veins

F. W. Kappelman, Milwaukee (Journal A. M. A., April 26, 1919), describes the method of treating varicose veins by injection of hot sodium chlorid into their lumen. He says he realizes the responsibility of introducing a new surgical method and mentions the discouragements he received on describing the methods of others. The object is to obliterate the lumen of the vessel in situ by destroying the intima and causing complete atresia of the vein. Of the problems to be solved, the more important were: (1) the minimum temperature at which the sodium chlorid solution (3 per cent) could give the proper results; (2) how to keep the blood out of the vessels during its introduction, and (3) how to prevent embolism. Each of these problems has been met successfully from the first, except the temperature, and this had to be tried on the patient. He therefore used the solution at the boiling point in his first operation. The result was not ideal because there was extensive sloughing of the surrounding tissues, but no ill effects otherwise. This showed that he could introduce solutions hot enough to produce the desired result. In the next two cases a temperature of 185 degrees was used, which was still too hot, as a small amount of sloughing occurred at one point. Since then he has employed it at 160 with perfect results. He describes his technic, in full, with all precautions used, the detailing of which does not lend itself readily to brief abstracting. The advantages claimed for it are as follows: "1. The operation requires only a few minutes; hence a short anesthesia. 2. It is

less tedious. 3. It is as easily accomplished in the presence of a large amount of panniculus adiposus as in its absence. 4. It involves a minimum amount of cutting. 5. It is cosmetically ideal. 6. The nerves are left intact; there is no dead sensation. 7. The lymphatics are preserved. 8. There is absolutely no pain after the operation. 9. The length of stay in the hospital is reduced to a few days."

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Lantern Slides on Cancer

The Executive Office of the American Society for the Control of Cancer (Room 1503, 25 West 45th Street, New York City) has a collection of nearly one hundred lantern slides suitable for use in connection with lectures on cancer before professional and general audiences. These slides, or selected assortments therefrom, will be loaned without charge to any state or local representative of the Society, or of a state or county medical society or other organization of similar standing, or to any properly qualified individual lecturer. Likewise, approved local committees or individuals will be furnished with duplicate sets of these slides at cost, which is approximately twenty-five cents a slide. Orders should be sent to the Society at the above address and the slides will be shipped and billed directly from the firm in New York which holds the negatives.

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Suprarenal Hemorrhage

F. B. Lusk, France, and A. Brumbaugh, Camp Dodge, Des Moines, Iowa (Journal A. M. A., April 12, 1919), report a case of hemorrhage into the suprarenal occurring without any traumatic cause, and notable for its much larger size than usual. The fact that streptococcus hemolyticus was isolated from the blood before and after death, and that the case followed shortly on an epidemic of empyema at Camp Dodge, due to the same organisms, suggests it as the exciting cause. It seems reasonable to assume that lodgment of a bacterial embolus either in the vessel wall or in a vessel itself might cause hemorrhage and death. The clinical picture up

to a few hours before death was that of a severe septicemia, which was the ante-mortem diagnosis. At the necropsy, the most striking thing was the position of the descending colon and an underlying hematoma. The hematoma, well confined retroperitoneally, extended from the brim of the pelvis on the left to the splenic flexure and thence to a point in the epigastrium, 4 cm. to the right of the median line in the region of the descending portion of the duodenum. It was pyramidal in shape and the base measured 18 cm. in width. The left suprarenal in its anterior surface showed a rent 1.5 cm. long and 0.2 cm. in width, running longitudinally and extending through the cortex into the medulla, communicating with a cavity 0.5 cm. in diameter and containing some liquid blood. No ruptured vessel could be found and microscopic examination did not throw any more light on the cause of the hemorrhage. The conditions in other organs are also described.

—R—

Hope to Make Dyestuffs More Cheaply

Cheaper processes for the manufacture of a number of dyestuffs and medicinal preparations will result, it is believed, from discoveries made by experts of the United States Department of Agriculture, who have been investigating ways of making certain sulphonic acids. With a view to helping the chemical industry of the country, the department is offering to co-operate with manufacturers in establishing the process on a commercial scale. The expenses of installation are to be borne by the manufacturing concerns co-operating. Experts of the color laboratory of the Bureau of Chemistry will be assigned to the plants and will assume control of the undertaking.

In all such undertakings, the stipulation will be made by the department that the manufacturing concern is not to divulge anything pertaining to the original process or to any that may be developed later, but that the right to patent any or all of these remains in the Department of Agriculture, these patents, if they are allowed, to be

dedicated to the free use of the government and the public.

In the laboratory experiments, the sulphonation of a number of hydro-carbons has been studied, and in some cases the laboratory work has reached a stage that large-scale experiments are necessary to prove the value of the process. The work on benzene is most advanced. Sulphonated benzene is used in the manufacture of resorcinol and of synthetic phenol. The laboratory work on the sulphonation of other hydrocarbons is nearing completion.

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Transplantation of the Uterus

Perhaps the most pitiable condition that man can suffer is that due to new growths in the bladder, says W. E. Lower, Cleveland (*Journal A. M. A.*, Aug. 2, 1919). In most cases, the suprapubic drain cannot give relief, nor can large doses of opium. The only possible method is by preventing the stream of urine from passing through the bladder, and this can be done by transplanting the ureter into the loin or into some portion of the bowels, preferably the sigmoid or rectum as near as possible to the bladder. If the transplantation is into the loin, some mechanical contrivance to catch the urine is needed, and this, as a rule, is unsatisfactory. On the other hand, if the ureter is transplanted into the large intestine, the annoyance is less, as the sphincter ani becomes adapted to the new condition and effectively controls the urine. The best technic for this operation, in suitable cases, is perhaps that of Coffey. "The operation is preferably performed in two stages, transplanting one ureter first and then waiting a sufficient time to be sure that the ureter is functioning in its new location, and to allow the sphincter ani to become adapted to the new condition, when the second ureter is transplanted. Preferably, the right ureter is transplanted first, as, if adhesions follow, as they often do, the rectum becomes more or less fixed and cannot so readily be drawn into the cut." In certain cases, a third operation for complete removal of the bladder may still better the condition and pro-

long the patient's life. He has performed this radical operation twice. In one case, the patient survived two and one-half years in comparative comfort. In the second case he lost track of the patient after six months, and has not been able to ascertain how long he survived. In both instances relief was immediate. In two other cases, the ureters were transplanted simply for relief, as the growth was so extensive that the more radical operation was impossible. The patients in both cases died within a short time, but relief had been obtained for the time being. If the patients present themselves early enough, the best results are possible. The division of the operation into two stages, or three, including the bladder extirpation, divides the trauma of the single stage operation to the patient's advantage. The four cases are reported. Lower thinks that, with bladder extirpation, the possibility of a complete cure may be anticipated. In the first case, that in which the third operation was performed, the growth returned and, involving the intestine, carried the patient off. In the second case, the patient was comfortable and in good condition as long as heard from.

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Sporting Note.

"Nuxated Iron put added power behind my punch and helped to accomplish what I did at Toledo."—Jack Dempsey.

Thus the new world's champion, in large advertisements appearing in last Sunday's papers—at least in such papers as need the money from such sources. The secret is out. We feel that an apology is due to those of our readers who rely on this department for their knowledge of sporting events. We admit to a lack of enterprise in not discovering earlier what was going on behind the scenes in Mr. Dempsey's training camp. But three short years ago, Mr. Willard was telling the public—at the expense of the manufacturers of Nuxated Iron—that that marvelous "patent medicine" was the secret of his easy victories over Jack Johnson and Frank Moran. Now the Honorable William Harrison ("Jack") Dempsey—also at Nuxated Iron expense—

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—R—

Prostatic and Vesical Cancer.

Frank Hinman, San Francisco (*Journal A. M. A.*, June 21, 1919), describes and illustrates an instrument for the radium treatment of prostatic and vesical cancer, modified from the catheter method of Young, allowing the patient to move more freely than was the case with the unmodified method. The value of radium in these conditions has been confirmed, or at least reported on encouragingly, by eminent urologists, but most of the methods have their disadvantages. Hinman's description is too detailed to be given in an unillustrated abstract, but he reports its satisfactory use.

—R—

Buttermilk Therapy

For reliable information with regard to new therapeutic measures and reliable brands of drugs proposed for them, *New and Nonofficial Remedies* should be consulted. This book contains a chapter which discusses the probable value of the Metchnikoff sour milk therapy. The book also describes those brands of preparations which the Council on Pharmacy and Chemistry found to be reliable and exploited recently.—*Journal A. M. A.*, April 12, 1919, p. 1099.



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Differential Diagnosis of Mental Diseases

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Read at the Annual Meeting of the Kansas Medical Society,
Ottawa, May 7 and 8, 1919.

The general practitioner must by force of circumstances be something of a specialist along all lines. This is particularly true of those engaged in country and small town work where special counsel is less available. Of all the recognized specialties which the general physician is called upon to practice there is perhaps none in which he feels his limitations more keenly than in the field of psychiatry. This is due in part to the lack of thorough grounding in the subject which he has received in school and to the further fact that he does not usually have an opportunity to study such cases nor observe their course for any extended period on account of a commitment to a sanitarium or state hospital. These cases all pass through the family doctor's hands however, and during this period there are a number of questions to be considered such as the urgency of commitment, danger of the patient doing harm to himself or others, the probable duration of the illness, the ultimate outlook, proper therapeutic measures, etc., for the solution of which a knowledge of the particular type of mental trouble present is very important. It is just here that the average doctor seems to have his greatest trouble. A well marked case of insanity presents such pronounced and characteristic symptoms that a general diagnosis of some mental derangement is usually made by the family before the

doctor is called in. It is a very different and much more difficult matter to determine the exact type of the psychosis. Such a differentiation is not always easy and in some instances is exceedingly difficult, but a well posted physician should at least be able to assign an ordinary case of insanity to the group to which it properly belongs. It is with the idea of stimulating study along this line and possibly giving some useful and practical hints that this paper has been written. There is neither time at my disposal nor is this the place to enter into a detailed discussion of various subdivisions and individual types of mental diseases, and I shall confine myself to the differentiation of some of the more common and frequently encountered forms of insanity which naturally fall into generic groups.

In the study of any subject, if the knowledge of it is to be readily comprehended, retained and put to practical use, it is necessary to proceed on the basis of classification. Up to some fifteen years ago the classification of the psychoses was most unsatisfactory. This is apparent at once upon an inspection of any number of old asylum or state hospital reports. Each institution followed its own lead and the tendency was towards intricate division into separate clinical entities until we had an array of various kinds of manias, melancholias and dementias, almost ad nauseum if not ad infinitum. The introduction of the Kraepelin classification did more than any other one thing to bring order out of this nomenclatural confusion. This classification, or a modification of it recommended by the American Medico-

Psychological Association, has now been adopted by practically all hospitals for the insane in this country.

Dementia praecox,

DEMENTIA PRAECOX.—The most important contribution of Kraepelin and the one which has had the greatest and most clarifying influence on psychiatry was the introduction of the term dementia praecox. This name is now applied to a group of cases which includes all those formerly classed as primary dementias and hebephrenias, and some manias, mild melancholias, and paranoias of the old classifications. It comprises about one-fourth of all admissions to state hospitals at the present time. It is a disease of early life, more than 60 per cent of cases occurring under twenty-five years of age, but it may develop well along in the fourth or in rare instances even in the fifth decade. Mental deterioration in a varying degree is an early and prominent symptom but the dementia is of a selective type, some mental faculties being profoundly affected while others show little impairment. Memory and orientation are usually well preserved and there is ordinarily little clouding of consciousness, while the powers of attention, the will, judgment, and the emotions are invariably defective. These patients are desultory in conversation, give expression to many silly and grotesque delusions, exhibit little or no affect, and are apathetic and indifferent to an extreme degree. Hallucinations are always present at some stage of the disease and often have a decided influence on the patient's conduct. While hallucinosis is by no means limited to this group, it is a symptom of great diagnostic value and should always be searched for in a case of suspected dementia praecox. In addition to the above general symptoms there are some which are of special significance in relation to the different types of this disease, such as the silly, mirthless, and unprovoked laughter, and the simple deterioration of the hebephrenic, the mannerisms, catalepsy, negativism, and stupor often changing to excitement of the cata-

tonic, and the vague unsystematized persecutory delusions of the paranoid form.

MANIC-DEPRESSIVE INSANITY.—Another valuable contribution made by Kraepelin to the nomenclature of psychiatry was the grouping together under the name of manic-depressive insanity two conditions presenting quite opposite emotional states, the manias and melancholias of the older authors. According to Kraepelin these two conditions, while very unlike in their symptomatology, are merely different phases of the same morbid process and should not be considered as clinical entities. Periodicity is one of the most striking features of this form of insanity which is marked by recurring attacks, the patient in the interim being entirely well mentally. This is a diagnostic point to be borne in mind and a history of such a course is very suggestive. This does not give one any help in the initial attack, however, when a differentiation from some other psychosis is at times quite difficult. A well marked hereditary taint points toward the manic-depressive form in which it is found to exist in about 75 per cent of cases. There is little tendency towards permanent dementia until the disease is of long duration with many recurring attacks when considerable deterioration is often found. The emotions are always disturbed, more or less euphoria and elation being characteristic of the manic phase while the depressed type presents a picture of gloom and sadness amounting at times to severe mental pain and anguish. The manic patient also shows great distractibility of attention and psycho-motor activity which may be confused with the catatonic excitement of dementia praecox. The manic presents a true flight of ideas through which some association can always be traced in contrast with the desultoriness of the praecox whose train of thought is loose, broken, and disjointed, often amounting to complete incoherence. The movements of the manic patient are purposeful while in catatonic excitement they are impulsive, senseless, and often stereotyped. Profound states of depression may

be confused with catatonic stupor but is distinguished from it by the presence of retardation which is a cardinal symptom of the depressed phase of manic-depressive insanity. The retarded patient is slow in thought, slow in speech and slow in action, but does not show the obstinate and persistent resistance found in the negativistic states of the stupid praecox.

CONVULSIVE DISORDERS.—Simple epilepsy without marked mental complications does not usually present a difficult problem in differentiatial diagnosis, but when convulsions are associated with an active psychosis the case is frequently erroneously diagnosed as epileptic insanity. One swallow does not make a summer and the single symptom of convulsions does not necessarily mean epilepsy. They occur in paresis and other forms of cerebral syphilis, arteriosclerosis, dementia praecox, brain tumor, and grave hysteria. The convulsions of paresis are apt to be prolonged and followed by much greater prostration than in epilepsy and are frequently accompanied by a rise of temperature. It is also often characteristic of them that they leave the patient on a lower plane mentally than before the attack. The presence of other and well known symptoms of paresis should make the diagnosis easy. In cerebral syphilis there are frequently cranial nerve involvement or focal symptoms which are suggestive. The convulsions of arteriosclerosis come on late in life and are associated with other evidences of arterial disease. Brain tumor is recognized by the severity of the headache and the other signs of intracranial pressure which accompany it. It is impossible to differentiate the fit occurring in the course of dementia praecox from an ordinary epileptic seizure unless the other symptoms of the disease are taken into consideration, but these symptoms are so characteristic and so different from those of epileptic insanity that there should be no trouble in differentiating the two conditions. The chief difficulty seems to come from overlooking the fact that convulsions occur in dementia praecox although their

occurrence is not very infrequent.

It is often exceedingly difficult to differentiate grave hysteria from epilepsy and the two diseases may be associated in the same patient. Memory defects do not develop in those suffering from hysteria to the same degree as in epileptics and there is much less tendency to mental deterioration in them even when they are subject to fits for long periods. The hysterical seizure itself is more apt to be of shorter duration, particularly the post-convulsive phenomena of stertor, sleep, and confusion. It has been stated by authorities, however, that every symptom of a genuine epileptic attack may be found in some cases of pure hysteria and that the only way they can be differentiated is by the use of hypnotism. Under hypnosis the hysteric can be made to recall incidents which occurred during the fit, while in epilepsy there is complete amnesia.

PARESIS AND OTHER SYPHILITIC CONDITIONS.—It is very important that paresis be recognized in the early stage. In its incipency there is possibly something to be accomplished in a therapeutic way by intensive treatment but otherwise the outlook is hopeless. There are other considerations in connection with this disease which should not be lost sight of and which demand that the patient be placed under supervision of restraint as soon as possible after mental symptoms appear. Estates may thus be saved which would otherwise be wasted by foolish and visionary investments and serious accidents often prevented. It is now recognized that syphilis is the essential cause of paresis and the dictum of "no syphilis, no paresis" is universally accepted. It follows therefore that the first step in diagnosis is to determine whether or not the patient is syphilitic. Both the blood and spinal fluid should be examined. If a positive Wassermann is obtained the cell content of the fluid should be determined and a gold test made, the latter being probably the most delicate laboratory test for paresis. The gold curve is also of value in differentiating between this and other forms of cere-

bral syphilis. In this connection it is well to emphasize the fact that it does not necessarily follow that all insane patients who show a positive Wassermann are paretics and therefore hopeless, as you may have a more benign psychosis develop in an individual who also has a luetic infection. The symptoms of a classical and well developed case of paresis are so characteristic that it is unnecessary for me to mention them, but there are some early signs which are not infrequently overlooked or misinterpreted. A large number of cases begin with what appears to be a simple neurasthenia and many of them are so diagnosed and the patient treated for that disease for months or until the development of some episode which calls for a more careful examination when the unmistakable signs of the more serious affection are discovered. An obstinate neurasthenia should therefore always call for a Wassermann test and in a person who is known to be syphilitic should at once arouse a suspicion of a possible early paresis. Apoplectiform and convulsive attacks sometimes occur quite early but are rarely if ever found without other suggestive signs being also present. They are not infrequently the first morbid indications to be recognized by the family and are the occasion of a physician being called into the case for the first time. Under these circumstances an erroneous diagnosis of apoplexy or epilepsy may be and at times is made by attaching too much significance to the convulsive symptoms and not looking for others which would determine the true character of the malady. Among the early signs of paresis which have a value in differential diagnosis may be mentioned changes in character, especially the development of irritability and peevishness over trivial matters, and a sudden transition from regular to intemperate and unconventional habits, memory defects especially in impressibility, tremors of the face, pupillary changes, and a tendency towards slurring speech.

We may have mental symptoms associated with either the meningeal or the vas-

cular type of cerebral syphilis, the former characterized by persistent headaches and cranial nervous involvements and the latter by focal and apoplectiform symptoms.

INFECTION AND EXHAUSTION PSYCHOSES.—As the name indicates this group comprises those mental disorders which develop in connection with infectious diseases or severe nervous exhaustion. Its exact limits and confines have been a source of much discussion and dispute. Some authorities include these two conditions together with various other psychotic states depending on somatic diseases under one generic head with several subdivisions, while others prefer classifying them separately under such names as fever delirium, post infection psychoses, acute confusional insanity, puerperal mania, exhaustion psychoses, amentia, etc. Being quite similar in both etiology and symptomatology it seems to me much more practical to classify them together. Under ordinary conditions this group occupies a secondary position numerically, but the pandemic of influenza of the last six months has been followed by a considerable wave of this particular form of insanity. It usually presents a rather definite and clear cut clinical picture of its own, but one should not lose sight of the fact that the same causative factors may produce a psychosis which naturally falls into some other distinct nosologic division. A person, for instance, who is of the mental make-up which predisposes to the development of dementia praecox may exhibit typical symptoms of that disease following a severe infection or under the stress of extreme exhaustion, or one subject to periodical outbursts of mania or depression may have such an attack precipitated by the same cause. The cardinal symptoms of the group under consideration upon which we depend for a diagnosis are: Clouding of consciousness, which may vary from mild mental confusion to wild delirium, impairment of attention, disturbance in the realm of perception, and apprehension evinced by vivid hallucinations and illusions, a tendency towards

amentia, and a more or less profound physical prostration.

PARANOIA AND PARANOID CONDITIONS.—

The term "paranoia" is used in a very much more restricted sense now than it was a few years ago and since the introduction of the Kraepelin classification there has been a great falling off in the number of cases so diagnosed. Most of those formerly classed under this head are now included in the dementia praecox group as the paranoid form of that disease, while some are referred to merely as paranoid conditions. These three diseased states resemble each other in that their most prominent symptom is the presence of delusions of persecution associated with grandiose ideas. The delusions of the several types differ in intensity and in the extent to which they influence the patient's behavior. In the paranoid praecox the same looseness of thought which is so characteristic of the whole praecox group is apparent in his persecutory delusions, which are vague, phantastic, and nonsensical, and his indifference usually prevents him from displaying any pronounced conduct reaction. The patient suffering from a simple paranoid condition presents little or no system to his delusions, which are often changeable and may ultimately disappear. The pathognomic symptom of true paranoia is the fixed and systemized delusion of persecution. The train of thought is apparently logical, but is based on a false premise. Sooner or later expansive ideas appear, but there is very little tendency towards dementia. The paranoiac has implicit faith in the belief that is in him and comes more and more to brood over his supposed wrongs for which he can not get redress. This mental trend finally dominates his conduct and may lead to the commission of some desperate act or make of him at all times at least a potential source of danger.

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Climatologists tell us that "There is no more perfect climate in the world than along the Pacific Coast between Santa Barbara and San Diego."

My Experience at the Front

J. G. MISSILDINE, M.D., Parsons

Read at the Annual Meeting of the Kansas Medical Society, Ottawa, May 7 and 8, 1919.

In this attempt to give you some ideas concerning my work with the American Expeditionary Forces I shall not confine my remarks to the medical or surgical aspect, since the work at the front consists of first aid and emergency medical treatment and is not of the most interest unless treated with the movements and experiences in general.

We left the United States early in July and found the following weeks not altogether happy since the submarine activity at that time was at its height. Life belts were constantly worn and frequent life boat alarms were given, all of which was real enough to furnish apprehension. We reached France the last of the month, via England.

A company of casual medical officers was sent from Cherbourg to St. Aignan, which is about a hundred miles south of Paris. After two weeks' instruction at this place in gas drill and the use of Thomas splints I was assigned to the third battalion of the Sixteenth Infantry, a part of the First Division. All luggage which one could not carry was left behind or promptly lost on the way to the front. I joined my outfit in a few days, going by train to Vaucouleurs, thence by automobile to Pagney la Blanche. Here the organization was receiving replacements and the men were being re-equipped, having just come out of the strenuous Chateau Thierry offensive.

At this time I made the acquaintance of the officers and men with whom my real work was to be done. To me this outfit of seasoned regulars was an innovation in the matter of associates, but I quickly learned that their hardness was the most valuable quality a man could possess when real fighting was on and this quality I soon realized was highly communicable to the newcomers.

From here on we marched, always by

night, to take part in the St. Mihiel offensive. During the day all the animals and vehicles were kept under cover of a woods, or camouflaged, and the men were likewise kept from the observation of the enemy aircraft. For several days we were within a night's march of our front line, expecting each evening to go into this much heard of drive, which started the morning of September 12. The night before I visited the front line trenches with a party of officers to make a reconnaissance, my especial interest being to acquaint myself with the ground to be gone over, and to pick out the best possible first aid post, always considering the availability of the ambulance service, easy access to the battalion while in action, together with as much protection from the enemy fire as possible.

Our sector lay almost immediately in front of Mt. Sec, which you may remember had been taken three times by the French but always lost. Although these attempts had cost over 30,000 lives, the front line had not been advanced. On the day before the drive, a conference of the officers of the regiment was held and we were informed that this engagement was to be a bloody affair. Our intelligence force had reported tremendous fortifications in the side and back of Mt. Sec, which was only separated from us by a couple of kilometers of low flat ground, in perfect view of the Germans. The outlook was not the most pleasant, but if I could give you some idea of the extent of the artillery preparation you would better understand why we felt confident and why the advance was such a glorious success. It began at midnight, the infantry of course being in front. We took our position in a little ruined village by the name of Ramblicourt; just a few rods back of us were the 75's—innumerable they were and splendidly effective. A short way back of these were the 155's, and still farther back the heavier field pieces and the coast defense guns, which had been mounted for the special purpose of battering Mr. Sec. The enemy were shelling us, only a little before midnight, and I was dressing the first lot that

came in, when our barrage opened. It was a terrific thing. I wish I could describe it to you, but it is impossible to give you any conception of such an affair. The magnitude of it, the entire exaggeratedness of it all requires such superlatives as would be extremely difficult to supply. As far to the left and as far to the right as one could see were the flames from the belching guns. The din was awful. The shells going over us made interesting yet weird sounds; the small ones shrieked, the larger ones howled, and the formidable ones from the coast defense guns sounded like overhead trains, so much so that the doughboys dubbed them "fast freights." As the shells exploded the mountain side was lighted up in a play of colors which was most extraordinary—some violet, some scarlet, and some of a greenish hue. This continued until 4 a.m., when we started over. The advance was made rapidly, the enemy offering little resistance. They had sought safety in dugouts, many of which were impenetrable except to direct hits. It will be remembered that 17,000 prisoners were taken the first day, with great stores of supplies, and the salient was obliterated the first two days.

One sees every conceivable type of wound and many acute nervous and mental disorders, chiefly neuroses, which are looked into as carefully as time will permit to determine whether or not they are genuine.

All of the medical corps men are skilled in dressing wounds and in emergency treatment in general. Morphine to prevent shock and to relieve pain was freely used and was of great value. Antitetanic serum was used as a routine measure, if not in the field, then at the ambulance dressing station. The supply of dressings is never large enough unless one has the luck to find a supply left behind by the enemy, in which case it was necessary to make sure that they were not left behind for the purpose of infecting those on whom they were used. Usually this was easily done. Everything, including sterile dressings, Thomas splints, and iodine swabs,

had to be carried by hand in addition to the regular equipment of army men, and naturally an abundant supply was impossible. It is regrettable that it was sometimes impossible to carry the load started with and that useful material had to be discarded. It was better, however, to be with the battalion with a limited supply of things than to be weighted down to a point where keeping up was impossible and not to be on hand when our help was needed. Keeping up was difficult, for the reason that one met wounded men every little while who required attention. In the St. Mihiel affair the prisoners were used for litter bearers, which saved our fellows splendidly.

Sharp criticism frequently came along from the medical officers farther back because of the failure to properly dress fractures, but to anyone who has followed an advancing outfit of enthusiastic Yankee infantrymen it is perfectly patent that whatever is done must be done quickly or the medical officer and his men are lost from the battalion, and of course of no further service to them.

Following the affair of which I have been speaking, we were sent into the Argonne sector near Verdun, where my division relieved the Thirty-fifth on October 1. This was quite different from the sector we had just left. The resistance was stubborn, enemy machine nests were everywhere, and we were constantly harassed by their high explosive, shrapnel and gas. It has been said that we lacked artillery support, which may be true, but if so, unquestionably unavoidable. The constant shelling of the roads made traffic almost impossible.

Here I was transferred to the regimental dressing station which was located in the demolished village of Charpentry. We used a dugout from which the Germans had been driven and from here evacuated the casualties from the battalions in advance of us. The number of wounded and dead constantly increased, which kept us all working day and night with little time for rest. Many of my friends and men I had

learned to like and admire were killed or sent back wounded, among them my orderly, a boy seventeen or eighteen years old, who had served me most faithfully, hit by a shell which mutilated an arm, and almost immediately he was killed by another shell. Nearly all of the first aid men with the regimental dressing station were gassed or wounded. About 3 o'clock the morning of October 3 I was gassed, which incapacitated me for work, and I was evacuated a few hours later. I was yet unable to return to my regiment when the armistice was signed.

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The physiologic-dietetic committee has proven that it makes no difference in the digestion and assimilation of milk and the benefit derived from its use whether it was sipped (eaten) or poured into the stomach through a tube. Chemists and physiologic investigators get too big a kink in their curves sometimes. Many years ago a bale of young dried prairie grass was sent to the bureau of chemistry, in Washington, D. C., for analysis as to its food value for animals. The department wrote back that its food value was practically "nil." Some cadaveric Texas steers began pasturing on the young tender prairie grass in May and fattened for the market by July of the same year. The Texas steers did not get the report in time.

R

The Kansas doctor will have to get a move on him if he keeps in the wake of the Southern California internist. Since the airplane sunburnt tonsil is so common here the physicians have taken the cure and are treating laryngeal tuberculosis and chronic sore throat by that method.

R

What is to be understood when a doctor's advice to a sick patient is to "Eat what you want" or "Eat what agrees with you"? One of two things, either that dietetics is a farce or the doctor is not posted on diet. Simplicity in diet is as essential to the health of the body as simplicity in the dosage of medicine is for the cure of the sick.

GENERAL PSYCHIATRY FOR THE GENERAL PRACTITIONER

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Secretary Kansas State Commission on Mental
Hygiene

FOREWORD

So profound has been the effect of the disease we call Influenza upon the nervous systems of its victims, and so numerous the results of its havoc upon minds and brains, that in view of the anticipated return of another wave of the epidemic in the coming winter, it behooves us to give some consideration to these dire complications which will probably succeed again in great numbers. If there were, as has been estimated, fully 1,000 severe and over 5,000 mild nervous and mental cases following influenza in Kansas last winter, what may we expect to be the totals by the end of 1919?

Kansas physicians have not had time or opportunity to pay much attention to mental disease phenomena. The mental disease specialists of the country have written much for their particular journals, and have made rapid advances (especially since 1914) in their field, but they have not had the vision or perhaps the means of putting before the general medical public the plain and simple facts of their specialty as it concerns the general practitioner and clinician.

This was my thought in preparing for THE JOURNAL OF THE KANSAS MEDICAL SOCIETY the three papers on General Psychiatry for the General Practitioner which follow, dealing in turn with (1) the newer classification and names and divisions of the diseases of the mind, which is replacing rapidly the older conglomerations of names and symptoms which were so confusing, (2) a presentation of the nervous and mental sequelae of influenza, called "influenzal psychiatric by-products," the effect of gripe on the human mind, and finally (3) a discussion of the TREATMENT of these mental diseases following influenza. These papers will appear successively in this Journal under the following headings:

1. A Simple Classification of Mental Diseases.
2. Influenza and Mental Disease.
3. The Treatment of Mental Diseases Following Influenza.

A Simple Classification of Mental Diseases

We are all familiar enough with that physician who gains his practice not by the accuracy of his diagnoses but by their grandiosity. His diagnoses, once mastered by the stumbling tongue of the dazzled family, are triumphantly borne from county line to county line, to the envy and dismay of all less fortunate folk who may have had merely typhoid fever, instead of *inimitable ecclesiastical hypertrophic precipitated enteritis*.

Once it was the custom—shall I say the policy?—of some specialists in mental diseases to overwhelm the general practi-

tioner who referred him a case of so called "insanity" with an onslaught of verbal monstrosities in lieu of a diagnosis, a *veritable barrage of logomachical frightfulness!* It would never do to state simply that such a case seemed to be one of brain syphilis; instead the general practitioner must be impressed by the fact that this case represents a spirochætal ependymo-encephalitis with psychiatric symptoms of psychic inversion and a curious admixture of pseudo-daemmerzustaende. (More frequently these wordy characterizations were less minutely accurate.) Incidentally, of course, it should not be forgotten that the delivery of a few high sounding (however meaningless) words in characterization of a disease of the mind leaves its deep impress upon the mind (and pocketbook) of the patient's relatives. Neither they nor their family physician are any wiser if the conglomeration of the words which the supposed mental specialist dispenses as a diagnosis be utterly meaningless.

Such, I say, was once a custom among certain specialists in mental diseases, and I will say it still exists as a custom among some mental specialists and as well some who lay no (just) claim to be specialists at all.

Mental disease remains mysterious, and hazy, and little known about, and for these very reasons lends itself to the form of charlatanry just described. But after all it is partly the practitioner's own fault that he is attacked by the nonsensical phrases and names of the pseudo-psychiatrist. Diseases of the mind are quite as capable as diseases of the body of being put into well defined groups with appropriate names (diagnoses), courses, treatment, and prognoses. Nor are these groups difficult of mastery. As a matter of fact most medical men are already familiar with them in a general way, and save for a few difficult points of differential diagnosis, most general practitioners could just as well make fairly accurate and scientific diagnoses of the type of mental disease encountered as to refrain, in an anxious despair, until completely overwhelmed by

the impressing verbiage of a pseudo-psychiatrist.

I emphasize the "pseudo-psychiatrist" because I do not believe that modern psychiatry countenances that sort of thing. It is the aim of those of us who are desirous of seeing psychiatry reach the place in medical life that we think it deserves, to disseminate knowledge of mental disease among the medical and lay public, rather than to withhold it from them by making it more mysterious and more dismaying. It is certainly not the spirit of Mental Hygiene to put the doctors more in the dark about these things, but to help them to be less so.

There have been numerous classifications of the various kinds of mental disease from the modern viewpoint and all these classifications are very much alike. It is not essential that any one be chosen or designated as the premier, but for the purposes of practicability, of plain usefulness to all, that of E. E. Southard of Boston is by all means the one of greatest value. It groups all mental diseases into twelve great orders, a sufficiently sharp differentiation for all practical purposes. Unfortunately, as originally presented* this classification of Dr. Southard's is couched in terms which are quite unfamiliar to those not actively engaged in neurological and psychiatric work. Consequently I have been presumptuous enough to assume the role of interpreter and present this list of *possibilities to consider in diagnosing your mental cases* in language of the Kansas physician, of which I am one. Speaking the Kansas language surely applies in the field of medicine as well as in daily life.

First of all there is the great group of SYPHILIS OF THE NERVOUS SYSTEM, a subject so broad that whole volumes of considerable size have been written about it and even about one species of it, General Paresis. It comprises many forms, but the one mentioned is perhaps the most familiar, although it is rivalled by tabes dorsalis

(locomotor ataxia). Some writers believe that at least 10 per cent of all persons who acquire syphilis, knowingly or unknowingly, eventually develop one of these diseases. The diagnosis can practically always be made with certainty, now, thanks to discoveries in the chemistry of the spinal fluid. Brain and spinal cord syphilis cases rarely have normal spinal fluids, and it should always be examined in suspected cases. This is important because syphilis of the nervous system is treatable and if taken early enough is often curable! The first question for the doctor to ask himself in every nervous and mental case is, Is this possibly an early case of brain-syphilis?

FEEBLEMINDEDNESS is the next group. There are thousands of feeble minded persons in Kansas (and in every other state) and every physician is familiar with one or more cases. Yet many do not realize that there are many types and forms of this trouble. A still more surprising thing is that *most* cases of feeble-mindedness are never recognized, and in fact often never suspected. For feeble-mindedness, like all other forms of mental disease (called in legal terminology "insane" when sent to institutions) is a matter of degree. There is a graduation of intellectual capacity right down from the genius to the idiot. Normal people occupy the middle zone. Below that zone is a zone of the just-a-little-bit-dull folks (children and adults). Below that zone is another one, often not recognized, the so-called morons. A moron is a high grade feeble minded subject, and they are very numerous. Many of the street girls of the cities are morons, and probably not less than one-fourth of all the prisoners in the penal institutions of the country are morons, or lower yet. For below the moron stage there are two others, imbeciles and idiots. Of these, too, there are numerous types and kinds, but these finer subdivisions could be dispensed with if the people could only be gotten to realize that there are many imbeciles in our public schools, of whom the teachers know full well, but whom the

*See Journal A. M. A., October 19, 1918.

physicians and the parents have oftentimes overlooked. No imbecile belongs in a public school!

EPILEPSY is the third group. We mean by epilepsy the classical idiopathic form, and not the various and sundry imitations of it. There is a strong tendency for doctors and laymen to call any form of seizure, convulsions, temporary unconsciousness, etc., *epilepsy*, forgetting that by so doing one shuts out the diagnostic possibilities of brain syphilis, brain tumor, encephalitis, and a number of other diseases in which seizures or convulsions occur. And by shutting out diagnostic possibilities, one shuts out treatment and curability possibilities.

DRUG DISEASES, the addiction to morphine and the mental disturbances consequent upon excessive alcohol and other drugs, constitute the fourth group. Fortunately these are so comparatively rare in Kansas as to deserve little more than mention. This point should be emphasized, however, that because a man who drinks develops some form of mental trouble, is *no* proof or indication that he has an alcoholic brain disease. This fallacy is very common.

GROSS BRAIN DISEASE is Group 5, and this includes all the interesting cases of intra-cranial trouble which neurologists study so minutely. Brain tumors come in this group, and apoplexies (infantile and adult), and infections such as the recent "sleeping sickness," and skull-fractures and brain cysts, and many other similar lesions. The symptoms, as every one knows, may first be quite general, such as headache and vomiting (although both of these are frequently absent), but later there develop the specific neurological symptoms upon which an accurately localized diagnosis may be attempted.

DELIRIUMS constitute Group 6. Delirium is a name that has been applied to all sorts of mental disease, and it has come to be very vague in meaning, but if we apply it to just those mental disorders which accompany physical disorders of acute or prostrating sort, we will make

ourselves fairly well understood. Every physician knows what the delirium of fever is. Of course the fever is not always present, but in its absence there are other signs of severe disease which the trained eye will not overlook. Thus even in some chronic diseases like pellagra and diabetes and pernicious anemia, there may develop symptoms which clearly belong to this group, and could be called deliriums.

MENTAL DISEASES of old age make up the next order. We all know the common form of this as "senile dementia," but it should not be forgotten that there are numerous other forms than the simple deterioration type. Moreover there are many cases which are neither "senile" nor "demented." Some forms of this type of trouble develop in persons as young as forty, or at least forty-five, and yet they belong in this group, because they are of that type. Another thing to keep in mind is that old people are not exempt from brain syphilis or brain tumor and various other forms of mental trouble, and it is not fair to any patient because he is approaching his three score years and ten, and has developed mental symptoms, to say that he is "a simple case of senile dementia."

Group 8 is a hard group to name. The best name of all is a rather hard one, SCHIZOPHRENIA. It is still called various things in various places, but probably "dementia praecox" is commonest. Adolescent insanity, confusional insanity, chronic delirium, catatonia, hebephrenia, dementia simplex, etc., are some of the names it is called or has been called. In some ways chronic delirium might be as good as any. But the characteristic and typical symptom about this form of mental disease is *queerness*. And this is what schizophrenia means. *Schizo* means splitting, and *phrenia* means mind. This quality of splitting of the mind, queerness, silliness, strange conduct, wild beliefs and foolish ideas, voices and visions and unbelievable things, all are common in this group. It is one of the most difficult kinds of disease to handle, and yet it is extremely common.

At least 40 per cent of the patients in the state hospitals are of this sort. They remain well of body but sick of mind.

Group 9 is a group of mental diseases characterized by a single symptom, the symptom described as PARANOID (meaning originally "like paranoia," one of the distinct species of this group formerly supposed to constitute all of it). This means the condition so often seen in which a person conceives of the whole world or certain parts of it as contriving against him. People are plotting against his life, or his wife is deceiving him, or people are talking about him behind his back, or there is poison in his food, etc. This attitude of mind of suspicion, or of conviction of hostility in the outside world, is called paranoid. The symptoms may appear in almost any form of mental disease, but in certain types it is the prominent and central symptom, and these are grouped together in this order. They include the so called "paranoiacs," as well as numerous other forms, and one of them a form which some authorities include with the preceding group because the patient's reaction to his beliefs is so queer. The writer believes they should all be placed here together.

Group 10 is the CIRCULAR PSYCHOSIS which is sometimes manifested as mania, and sometimes as melancholia, even in the same individual. It is a curious disease which is quite common, and which is a perversion of the emotional faculty, either up or down. Fortunately it is usually curable or recoverable.

Group 11. This comprises all the HYS-TERIAS, neuroses, neurasthenias, psychoneuroses, etc. They are exceedingly common, and every doctor has his dreaded hypochondriacs which belong to this group, as well as his neurasthenics, and the rest. The "shell-shock" cases in the war, of which we read so much, were in about 95 per cent of cases instances of this group of mental disease. They are the abnormal psychological reactions to the unpleasant, conscious or unconscious, existent or non-existent.

The last group, Group 12, is composed of the miscellanies that are left over, the vague unclassifiable sorts, and also those abnormal mental states, born rather than made, which fall short of frank "insanities" in point of quantity rather than quality.

This is all. We have now covered the possibilities for diagnosis of *any and every case of mental disease* that exists, in the present state of human (psychiatric) knowledge. To review this list in tabular form, we have considered:

1. Brain syphilis;
2. Feeble-mindedness;
3. Epilepsy;
4. Gross brain disease;
5. Drug diseases;
6. Deliriums;
7. Mental disease of age;
8. Schizophrenia;
9. Paranoid diseases;
10. Circular psychosis (mania and melancholia);
11. Psycho-neuroses (hysteria, etc.)
12. Miscellaneous (this group is really called the group of *Psychopathy*, but I hesitate to introduce this additional neologism after what I have said about psychiatrists and their big words!).

There is a peculiar significance in the way in which the groups are arranged in this classification. They are placed in the order of diagnostic difficulty. This means that the first group is the most easily or most definitely diagnosed, the next one is somewhat less easily made sure of, and so on down the list, the last ones being the most difficult. The purpose of this was simply that in considering any particular case, one could simply begin at the top, with *brain syphilis*, and proceed down the list, excluding one group after another in succession until the correct group was reached, which would be quite impassable.

Suppose a mental case is to be classified or diagnosticated now, according to this scheme. Let us suppose it is a case of a woman who has lost her husband and is profoundly blue over this (and other

things). Despite the immediate impression one might have of the diagnostic probability of melancholia, one should first try to exclude *brain syphilis*. Syphilis of the nervous system very frequently manifests itself by just this sort of depression, with just such a good cause as in this case, and can only be distinguished from other depressions by neurological signs and laboratory examinations. This means complete physical examination and analysis of the blood and spinal fluid. Supposing it excluded then, we consider *feeble-mindedness*. Of course the accurate way to determine the presence of mental defect or deficiency is the application of the Binet test. Most general practitioners do not have this available. It is largely a matter of accurate knowledge of the patient's past history which guides them in a diagnosis, but that this may fail is demonstrated by a case who had consulted successively twenty-six other physicians. Not one of these physicians apparently considered the possibility of feeble-mindedness, although some had thought her possessed of some mental disease (*i. e.*, "insane"). She was not insane and she *was* feeble-minded. She was sent to a state institution.

Epilepsy would be considered next and could probably be ruled out by history. The *drug diseases* could usually be excluded by a careful inquiry among relatives. It should not be forgotten that depression may be a symptom of any sort of mental disease, including drug habit.

Brain tumors and other gross brain diseases of the fifth group, sometimes show as a first symptom simple depression, such as in our hypothetical case. To make the diagnosis in these cases, expert examination is really preferable. Sometimes the signs are quite obvious, as vomiting and headache with choking of the optic nerve papillae may indicate it clearly. These signs, however, are unfortunately not always present in time to make the very necessary early diagnosis.

Delirium is the mental disease picture accompanying *bodily* disease elsewhere,

and bodily disease being excluded, this diagnosis could be excluded, in any case.

Whether or not our patient was manifesting a depression belonging to one of the various forms of mental disease associated with old age would depend of course in part upon the age of the patient. Further than this it might be difficult for the general medical man to differentiate since these are among our most difficult problems.

Schizophrenia is of course the hardest style to cross. In general one may say that the depression that occurs in this disease is a *queer* depression, just as the whole disease is queer and everything that occurs in it is queer. This is another one of the points final judgment upon which may have to be referred to the special worker.

Next comes the group of *mania* and *melancholia*. As every one now knows, they are very closely related, despite their utter difference. It is here that one might think offhand to place the case we have been considering, but it is now apparent how many possibilities of error would thus have failed to have been considered or eliminated.

There remain yet two groups, *psycho-neurosis* into which this case might well fit, as neurasthenia, neurosis, hysteria, psychogenic depression, etc., and *psychopathy* or the miscellaneous form of psychosis. Both of these groups should be considered before a final diagnosis is arrived at.

Thus we have embraced the whole sphere of mental diseases, all within the compass of twelve names. Why give them names? Why decide upon the appropriate name for this or that specific case?

First for the purpose of prognosis, which is what the relatives want, secondly for the purpose of treatment, which is what the patient wants. Both of these depend absolutely of course upon the diagnosis. One may depend upon the other. For example, if we have made a diagnosis of brain syphilis, we can give a prognosis *with* treatment and a distinctly different

prognosis *without* treatment. The prognosis depends on the treatment. In some cases the treatment depends upon the prognosis.

This, then, is the goal of my little excursion into the reasons and existence of names of things, psychiatrically speaking. Mental diseases, like physical diseases, have names *other* than "insanity," which is no name at all. Give them their names, for they are neither hard to learn nor hard to apply, and upon them depends prognosis, and treatment, and the moral satisfaction of competent but diffident doctors.

—————R—————

Excerpts—By The Prodigal

PATERNALISM

The tendency of the age is toward paternalism. Paternalism is doing for the man what he should do for himself. It is the continuation of childhood care to the adult. "Paternalism is the principle or practice of a government" or governing body "that undertakes to supply needs or regulate conduct of the governed in matters affecting them as individuals as well as in their relation to the state" or governing body "and to each other on the assumption that it can best determine and secure their highest welfare."

The bug is in the medical profession. The propaganda is seen cropping out in the advocacy of the wholesale treatment of the sick. The germ is in corporation practice and so long as it was and is restricted it serves a purpose and has a place.

The principle has a grain of truth in it; but when carried too far or continued too long in practice tends to destroy the purpose it serves. This was illustrated in the Hun. As a paternalistic machine en masse, he was almost irresistible. But when left to himself, individually, without somebody to tell him what to do, the machine failed and was junked.

In other words paternalism destroyed the initiative of the individual units and when separated or the connection was

broken failed to function effectively and was Yorked. This is a weak point in paternalism.

Communal housekeeping is another illustration of fatherly care elongated—and ennuied. A readjustment is on the way in the practice of medicine; and surgery has set the pace. But the change must be made in such a way that the individuality of the general practitioner is preserved. He must remain the prominent factor in the profession. He must not be swallowed up and overshadowed by each and every specialism nor lost in mass formation. He must be where he can stand up and be counted. In this way his personality is preserved. He is put on his mettle. When left to himself he will not be helpless. He can be identified, he is stimulated to action because of a personal responsibility. Failure and success are both stimuli to work, study, investigation and progress.

It is well to have a general supervisional body, but each physician must work out his own salvation in his own way. He must be protected in his patients in so far as he is able and capable of building up a practice and holding it. He must not be interfered with by paternalism or specialism.

The community hospital is one way of protection. It need not be elaborate, but it would be a better place for the sick and a cleaner one than the average home. The expense would be but little if any more. The care would be more satisfactory, each doctor could follow his case, be responsible for it and get credit or censure as he might deserve. He would not get lost in the shuffle of mass formation and specialism—or paternalism. It would stimulate him to study and to investigate for himself. "As iron sharpeneth iron so doth the countenance of a man's friends." The association of the community physicians would broaden the vision of each one and the intimate acquaintance, each with the other, would enable them to do team work to the betterment of the community sick and to their own uplift.

READING AND STUDY

The average man reads—but few men study. By reading and study men become literary. They become acquainted with letters and have book knowledge. He is not illiterate who can read and write. He may be a literator, a smatterer. A man may be a great reader and gain but little knowledge. Better a little reading and much study than much reading and little study. Few men are great readers and students. This is a trying age in literature. It is trying because there is so much of it. It takes a wise head to know what to read and study. The inexperienced student is placed in a dilemma. The literature is so abundant and so contradictory that he gets bewildered; loses his head; becomes a scanner and is superficial. He can stick no peg in the wall of memory to hang a thought on. In the professional fight he has but little to tie to and sails around in the atmosphere.

This is the fault of the age. It is an age of newspapers, magazines, periodicals and books; professional, non-professional and nondescript. They bewilder and confuse. Things get jumbled up in the mind. One is liable to become a literary illiterate.

It is easy to point out defects in an educational system. The world goes to extremes. If it did not there would be no mean. Hence it is not an unmitigated evil that it is so. It is the way of evolution, of progress. It takes work and wisdom to select what can be used out of the mass of material. The author and editor can minimize the labor of the student by elimination. Long drawn out epistles of experiments ending with probabilities and uncertainties should be severely limited in their publication for the general professional student and physician. Such reports are metaphysical, "that fertile field of delusion propagated by language." If what is known facts only were published, there would be a dearth of reading matter, but study and reflection would have time to get in their perfect work.

Comparing experiments and mapping out the course of procedure with results

should be encouraged. But so long as there is uncertainty and probability only it would be economy of gray matter to abridge. But few men have ability to experiment and investigate with practical discernment. An investigator has an unbiased mind. He does not believe that a thing is true as a rule, but is a doubter. In other words it takes positive evidence to prove or disprove a proposition. The test of a physician's professional ability is in making a diagnosis by exclusion—by what the disease is not.

Conclusion.—Let the investigators, experimenters, statisticians and reporters suppress metaphysics. Wait until they can give facts, the only things that count.

LET THEM NAME YOU

A recent graduate in medicine must not get chesty. He must disabuse his mind of the nebulous idea that a physician lives outside the normal human life; outside the life of the laity. He should remember that he is one of them, only more accentuated. That he knows physical and mental ills and the source from which they come and some of their causes. He must not assume the air of "Now, God, I'm here"—of the psuedo-cult. Although a full fledged M.D. and entitled to the name and honor, he must be patient and discreet. By so doing he will get along better than Alex Blank who came home a fresh M.D. When his old neighbors began to "Alex" him as usual, he said to them: "I want it to be distinctly understood that from now on I must be addressed as Dr. Blank." And poor Alex is wondering why he failed in practice in that community and had to move on. The young graduate cannot know from experience that, when old friends and associates who employ him continue to call him Lewie, Ed or John, it is a mark of the highest esteem and of true and genuine friendship. The name is considered bigger than the title.

JOB WORK

Job work in medicine does not get the

best results. This is illustrated in government work. The work is done neither as well nor as economically as in private practice or business. The weak link in the chain of job-practice is the lack of personal responsibility.

The job work in an institutional or a corporation medical work shop, if cheaper than in a private one, is done at the expense of material. This waste and destruction of material makes it more costly to the party furnishing it. In a corporation where thousands of men are employed, the institutional medical work shop appears to be the only way out. At any rate it continues and no other adjustment is in sight. A readjustment appears to be on the way requiring corporation physicians and surgeons to confine their practice to corporation work. This can be done in the large centers or where there are corporation hospitals. It would work a hardship to the sick or injured employed outside of the places mentioned.

The cost to the corporation would be no more, for the employe foots the bill. But it seems that there is no good thing that is all good. A corporation has no soul, and a doctor, who is supposed to have one, will become corporationized. Like begets like. And the doctor confined to corporation routine practice loses touch with the outside world and the human kinship and sympathy that spurs the private practitioner on and makes life more worth while to him. The corporation doctor with a fixed salary has a financial advantage over the outside doctor who depends upon his private practice. And there is a tendency to slight the job work if the private or outside work pushes the corporation doctor. Our talk so far has gotten us in the fix the cooper was in who had his son get in the barrel to hold the head up while he put the top hoop on and headed the boy up in the barrel.

However, it is with the hope of fanning the flame of progress and betterment into present methods of dealing with the corporation sick and by doing so help to remove the wall of partition between the

private practitioner and corporation doctor and to equalize the advantages, thus removing all friction, and to see "how good and how pleasant a thing it is for brethren to dwell together in unity."

WASTE

The meat packer's profits are made from what he used to throw away. The medical profession is slow in learning the lessons the packer has learned and used to his enrichment. There is too big a minority of patients treated outside the regular profession. This is a waste or loss to the profession. It is carelessness or a lack of appreciation by the physician of the importance and value of this waste product to him. He not only sustains a loss, but he limits his field of usefulness by a loss of clientele. If this is not true, why do so many patients go to the uneducated healers?

An educated physician knows man as he is. He knows him physically, mentally and morally. He is prepared to treat him as a trinity. He should do so. By so doing he protects himself and the profession and adds to his own well being. He protects the patient and does away with sham and hypocrisy. The physician is prepared to treat the patient suggestively—Christian Science—when suggestion alone is indicated. He is prepared to find the bumps, knots and spinous processes along the backbone. To find the sore places or tender spots and rub them, knead them and yank the neck and stretch the spinal column and make it crepitate; pound him over the origin of the solar plexus two dollars' worth, and the patient will feel better than if you give him a dose of salts. Give him a half to a dozen treatments and you will cure one-half of your old lame back neurotic patients.

This talk may amuse you or disgust you, but if you will go with me some day to the chiropractic school in this city where from forty to fifty patients are treated every day and see the good results of such manipulation, you will think better of the by-product and begin to use it yourself.

In osteopathy the physician is the man prepared to do the work. And so on down the line of so-called specialties. The physician has the advantage in diagnosis and would not massage, osteopathize or chiropract a purulent appendix, an aneurysm or a necrosed spine. There is a world of work for the general practitioner if he will conserve it and do it aside from the recognized scientific specialties. It will also broaden the field of medicine for the general practitioner. He will be relieved from the fear that legitimate specialism will circumscribe his practice to the navel.

When The Prodigal began the practice of medicine he prescribed one-tenth of a grain of calomel for a dose. The profession called him a Homeopath. Such sized doses were considered infinitesimal. They all prescribe them now. He met the Homeopath, the Eclectic or the midwife at the bedside, said what was said before the patient and family, trusting to the largest pole knocking the persimmon. He was never vanquished. There was nothing in those day in athies and ectics to vanquish.

The chiropractor, osteopath and many other technical special pseudonyms are getting the milk out of the cocoanut and the educated physician gets the shell. Whose fault is it? Get busy. Study human nature. Meet the wants of humankind. Treat them as you find them and not as you would have them to be. Gold is where you find it. If you have a patient, keep him. Meet his requirements. If he is visionary, imaginative, flighty, hysterical, off mentally, physically or morally, try and measure up to the occasion and don't lose him from lack of ability on your part.

TINY

The older physicians, now living, were taught that an atom was indivisible. The physician of today is taught that the atom of each element represents a stable arrangement of a number of electrons. That an electron is one of those particles, having about one-thousandth the mass of a hydrogen atom. True probably, but get-

ting filmy for etching on memory's tablet of the senile.

FADS

Man is a faddist. A faddist is an eccentric. An eccentric is out of center—an irregular person, an oddity. Some persons are more so than others. But none are exempt. There are physiologic and psychologic faddists. In the running they are neck and neck. Both are probably harmless. They come out of the same hole they went in.

Fletcherism is a harmless fad. The physical force or energy required to pulverize the food into atoms equalizes in loss the benefit resulting in its digestibility. Hence don't overwork the masseters, unless the mind needs it. The chewing gum habit is an illustration of the psychologic help or therapeutic benefit. It is a question, then, in its use, of dollars versus sense.

—R—

Cinchophen: Formerly Atophan

The Chemical Foundation, Inc., which has purchased some 4,500 German-owned patents, many of them for synthetic drugs, proposes to continue the wise policy of the Federal Trade Commission by requiring that those who receive licenses for the use of patents for synthetic drugs must use a common designation for each drug selected by the foundation. Cinchophen has been selected as the designation for the substance introduced as atophan (also described in the U. S. Pharmacopoeia under "Phenylcinchoninic acid"). In consideration of this action on the part of the Chemical Foundation and also because physicians found it difficult to use the pharmacopoeial name, phenylcinchoninic acid, the Council on Pharmacy and Chemistry has recognized the contracted term, cinchophen, as the name for the drug introduced as atophan. (Jour. A. M. A., August 9, 1919, p. 427.)

—R—

Milk should be eaten (sipped) by the sick, chemical faddists to the contrary notwithstanding.

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Blood Pressure Interpretations

Although we have comparatively little definite knowledge of the factors concerned in the variations of blood-pressure, the assurance with which most authors interpret the blood-pressure findings in a particular case or a particular disease is rather surprising. Not more surprising, however, than the very radical differences in those interpretations as made by different authors—sometimes by the same author.

It is perhaps true that the observations of many clinicians over a considerable period of years have reduced to a practical basis many theories regarding blood-pressure, but how much of that which is now accepted rests upon a real scientific foundation is open to question. The uncertainties in the matter of blood-pressure are well put by Faught (Blood Pressure, 2d Ed.): "When viewed from the standpoint of the human organism, involving as it does many complex and interrelated mechanisms which are in turn affected both by internal and external conditions, it is evident that so many factors must enter into this consideration that we are forced to the conclusion that the study is a complicated one, which can only be understood by a most careful consideration

of the sum of many internal and external influences affecting the cardio vascular system and the kidneys."

As a basis for interpreting blood pressure findings two general principles are accepted. The systolic or maximal pressure indicates the maximal force exerted by the cardiac systole and is approximately a measure of the intracardiac pressure. The diastolic or minimal pressure, on the other hand, is the measure of peripheral resistance.

Pulse pressure is a term used to designate the variations in blood pressure during a cardiac cycle, or the difference between diastolic and systolic pressures. The significance of the pulse pressure, except as it expresses the difference between the maximal and minimal pressures, is a matter of speculation, although it has apparently come to be of more importance in blood-pressure findings than the diastolic or systolic. Its introduction as a distinct and definite part of the blood-pressure phenomena is, to say the least, unfortunate.

The relation between diastolic and systolic pressures is admitted to be of the greatest importance and if the term "pulse pressure" is used simply as an index of this relation, very good, but attempts to attach to it any other significance leads to confusion.

We are told that in general blood-pressure depression a small pulse pressure means a greatly affected heart—that is, when both diastolic and systolic pressures are low, but the systolic lower in proportion than the diastolic, the heart is probably seriously disabled. We are told that a low systolic pressure and a large pulse pressure means loss of vasomotor tone and heart weakness—that is, when both diastolic and systolic pressures are low, but the diastolic lower in proportion than the systolic, there is both cardiac weakness and loss of vasomotor tone. But we are also told that in decompensated myocardial cases the pulse pressure becomes large, approaching, sometimes exceeding, the diastolic, and indicates great danger of

myocardial failure. But since it is not stated whether the pulse pressure is enlarged at the expense of the diastolic or by the increase of the systolic pressure, the observation is valueless.

Again, we are told by one of the best authorities on blood pressure that in heart affections a rapid and persistent reduction in systolic pressure shows that the heart is beginning to fail, and that a diminishing pulse pressure also indicates cardiac failure. This is plain enough, for, if the systolic blood-pressure is a measure of the force of the cardiac systole, any marked reduction in systolic pressure would evidence a weakened heart muscle; and when systolic pressure is reduced without a corresponding reduction in diastolic pressure the pulse pressure is also reduced, for the pulse pressure is always the difference between diastolic and systolic pressures, and never anything else.

The so-called pulse pressure may approach or exceed the diastolic pressure when the systolic pressure is increased or the diastolic pressure reduced. If we have a diastolic pressure of 80 and a systolic pressure of 160, the pulse pressure will equal the diastolic, but one would hesitate in saying that a heart capable of producing a systolic pressure of 160 m.m. is in a condition of muscular failure. If we have a systolic pressure of 135 and a diastolic pressure of 65, the pulse pressure exceeds the diastolic, but the evidence is rather of loss of vasomotor tone than of cardiac failure. If we have a systolic pressure of 100 and a diastolic pressure of 50, the pulse pressure equals the diastolic, and the low systolic pressure indicates cardiac enfeeblement while the low diastolic pressure indicates a loss of vasomotor tone, or of some other factor concerned in maintaining peripheral resistance.

Unless the basic principles for the interpretation of blood-pressure findings—*i. e.*, diastolic pressure is a measure of peripheral resistance and systolic pressure is a measure of cardiac force—unless these principles be changed or modified,

one is safe in the conclusion that the so-called pulse pressure has no significance except when considered in connection with the systolic and diastolic pressures and that any observations upon pulse pressure alone are valueless.

No careful clinician attempts to estimate the relation between blood-pressures with mathematical precision, but it is generally conceded that approximately the diastolic pressure is to the systolic as two is to three, in which ratio the pulse pressure would naturally be one. Considerable variation in these ratios is not inconsistent with normal conditions, but some of us are inclined to juggle the figures sometimes in order to make our observations harmonize with the standard of ratios. In a paper recently published in one of the current journals the author says: "The average pulse pressure in some 300 patients examined is about 35 m.m. of mercury and the average systolic pressure of the gynecologic case is about 130. This gives us a relation of a little more than one to three, as an index of the cardiac force. Suppose, however, the pressure readings were 140 over 80, this would give a pulse pressure of 60, or 60 into 140, which is but $2\frac{1}{3}$." Since the average blood-pressure of the 300 cases is used to establish the ratio we presume they were regarded as normal, in so far as the blood-pressure was concerned at least. Now if the ratio between the average pressures in his 300 supposedly normal cases is figured in the same way, 35 into 130, the result is 3%. In the hypothetical pathologic case mentioned the systolic is $2\frac{1}{3}$ times the pulse pressure, while the average systolic pressure in his 300 supposedly normal cases is 3% times the average pulse pressure. In other words the pulse pressure and systolic pressure in his pathologic case are nearer the standard ratio of 1 to 3 by $\frac{1}{21}$ than are the average pulse pressure and systolic pressure of his normal cases.

Another mathematical inaccuracy of this sort occurs in one of our standard text books on blood pressure. In establishing

the ratio of pulse pressure to diastolic pressure as one to two, reference is made to the clinical observation of "sixty-one normal persons whose average pressures were systolic 123, diastolic 80, pulse pressure 40." Since the only method for computing pulse pressure is by subtracting the diastolic from the systolic pressure, the true pulse pressure in these cases would be 43 instead of 40, an error of $7\frac{1}{2}$ per cent. An insignificant matter when computing the pressures of a single case, but in computing the average in sixty-one cases it is a matter of some moment. For, it will be observed, in a group of 300 cases the pulse pressure was to the systolic pressure as 1 to 3.71, while in a group of 61 cases the ratio between pulse pressure and systolic pressure is 1 to 2.86, and the ratio between pulse pressure and diastolic pressure is 1 to 1.86. It will be observed that these observations were cited to establish the normal ratio between pulse pressure and systolic pressure as one to three, and the ratio of pulse pressure to diastolic pressure as one to two.

Among the many suggestions as to the significance of the pulse pressure may be noted the claim that it indicates the cardiac load and overload—just what that means is a little indefinite but apparently it is intended to convey the idea that the work which the heart has to do may be estimated by the pulse pressure. The load, for instance, being the amount of energy expended by the heart to maintain the circulation in excess of that required to open the aortic valve, which in the normal condition is 50 per cent of the diastolic pressure. On this basis the author figures that when the pulse pressure equals the diastolic pressure there is a cardiac load of 50 per cent and an overload of 50 per cent. The inference is that when the peripheral resistance is low the heart must expend more energy than when the peripheral resistance is high, a conception which is hardly tenable. If the systolic pressure is a measure of the force of the heart there is no more effort expended when the diastolic pressure is 80 and the

systolic pressure 140 than when the diastolic pressure is 100 and the systolic 140. If there is an increase in the cardiac load it should be in the latter case.

It is well to bear in mind that what we choose to term diastolic pressure is lateral pressure and that systolic pressure is end pressure or the force exerted by the cardiac systole and transmitted through the artery to the obstructing cuff of the sphygmomanometer. The one represents arterial pressure and the other cardiac force and, by the auscultatory method, now most generally used, both are estimated during systole.

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Hypoadocrinism

Since the experiments of Horsley and Murray in the therapeutic use of thyroid extracts in the treatment of myxedema the subject of endocrinology has been of steadily increasing interest. Efforts to determine the physiologic action of the internal secretions and their relations to each other have helped to clear up some conditions that were not understood. Experimental therapeutics has also done something along this line.

The gross physical changes resulting from early castration in human beings and animals are said by Novak to be due to the removal of the inhibitory influence of the testis or ovary, allowing for an overdevelopment of the hypophysis. It seems probable that the effects of castration after maturity have been greatly exaggerated and those which occur with any degree of constancy are more likely due to a disturbance of the balance in endocrine function than to a loss of any direct influence of the testis or ovary. It is probably true that there are many conditions occurring in females at the menopause, not otherwise accounted for, that may have their origin in some disturbance in the endocrine balance. The grosser lesions of hypothyroidism are readily recognized, but there are many conditions in which no definite relation to deficiency in thyroid secretion is manifest, that are greatly benefitted by the administration of

gland extracts, if we are to accept as evidence some of the clinical results reported. In an article by Bate, which appeared in *American Medicine* last November, the author reports a series of cases that might belong to the class we have referred to, but to the ordinary practitioner he may appear a little over-enthusiastic in the following: "Almost miraculous results follow the use of thyroid in genuine hypothyroid headaches, joint pains, 'growing pains' and adult stiffness and soreness, retarded growth, dullness, constipation, subnormal temperature, coldness, acidosis from deficient oxidation, diurnal drowsiness, nocturnal insomnia, brittle nails, ununited fractures, loss of hair, especially outer third of eyebrows and nape of neck, lowered resistance, acne, psoriasis, eczema and herpes, neurasthenia and melancholia; disturbed menstrual condition, nocturnal enuresis, enlarged tonsils, adenoids, soft bones, tumors, and many other conditions due to hypoadocrinism."

If there are physical defects and functional disorders that are directly due to deficient secretion of one or more of the glands of internal secretion and other physical defects and functional disorders that are due to an imbalance in the physiologic action of those secretions, a considerable field for the application of gland therapy must be admitted to exist, a therapy, however, which must be largely experimental. For, until we understand more fully the chemical correlation of the organs and the interrelation of the glands of internal secretion, we may not scrutinize too closely the diagnosis of endocrine pathology. Nor may we be justified in using gland extracts indiscriminately. We have no definite clinical picture of the results of a disturbed endocrine balance or of hypofunction of the glands of internal secretion, in minor degree, but this does not justify the routine administration of glandular or pluriglandular extracts in cases of doubtful diagnosis, or in those that do not readily respond to other forms of treatment.

Salvage

It may be that the generally unsettled state of the industrial world has enlarged our views of the value of man-power, but whatever the influences that have brought it about, the salvage of the wrecks of humanity—not only the social derelicts, but also the physically disabled—is growing in popularity and in practicability.

Newer methods are supplementing or replacing older ones. More efficient and more adaptable mechanical devices have been invented. Special facilities and special courses of instruction are being offered for the re-education of those who have been handicapped by disease or injury. More effort is being concentrated upon the practical education of the blind and upon the means for rendering them independent and self-supporting. The limbless are being re-educated for occupations in which the limb is not required or in which a mechanical appliance may be utilized in place of the missing member. In the ataxias of tabes, co-ordination is being restored by proper methods of muscle training so that the usefulness of many of these unfortunates is greatly prolonged. The damaging results of poliomyelitis are greatly mitigated by modern methods of treatment and training.

We have been living in an age of prevention. We are entering upon an age of salvage, of restoration, of rehabilitation. The great war taught us that too large a per cent of our male population, of military age, is practically or completely incapacitated, and that this incapacity is largely due to preventable disease. The great pandemic has taught us that our means for prevention are inadequate and uncertain, so that more stringent quarantine regulations, more thorough surveys of afflicted communities are to be expected. But in addition to this there is a widespread and growing interest in the restoration of those who have already suffered, culminating we may hope in some organized system by which life's handicap may

be removed from those who have suffered from the inefficiency, the carelessness, or the stupidity of others.

In Kansas we are spending millions for education. We believe in it. We provide highly trained specialists in language, in mathematics, in science, and in art. We spare no expense in training the minds of our children so that they may be mentally equipped for any of the duties of citizenship the future may demand of them.

But yonder is a youth in whom there may be the mental qualifications for a great general, the imaginative and analytical mind of a constructive genius, or the curiosity and the courage of a great explorer; and he can do nothing with all the mental attainments our much lauded educational system has given him because of his pancake chest, canary muscles and spider legs. Here is a girl who has been carefully trained in language and literature and art. She is a fluent linguist and a finished pianist, but what a prospect for a wife and mother, with that contracted pelvis, that hollow chest and those rounded shoulders.

We are spending millions for mental training and a few thousands for very inefficient and very indifferent physical training. The physical training most commonly found in our schools and colleges is unadapted to the needs of those whose requirements are most urgent. In fact, those who really need it are barred from participating in the exercises prescribed. They are physically incapacitated for that kind of exercise.

Every school should have a course in developmental and reconstructive physical training with a sufficient number of expert instructors to provide for the needs of every pupil. The world needs men and women with brains, but it also needs men and women with both brain and brawn.

It was found that a very large per cent of our young men were unfit for military service because of conditions resulting from preventable diseases. Many of these conditions could have been remedied and

many others could have been minimized by the proper physical training at the proper time.

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Some of the Rules of the Board of Registration and Examination

We have so many requests for information in regard to the regulations of the Board of Examiners that we have asked its secretary for a statement of the essential matters relating to examination for license to practice in Kansas, and the regulations governing reciprocity with other states. The following important rulings have been selected from the literature received:

1. Applicants who desire to practice medicine and surgery in the State of Kansas must file their applications with the secretary of the board at least ten days prior to the day set for the examination which the applicant desires to enter. For examination, nothing but "A" and "B" class schools are recognized.

2. The applicant must, in every case, present his or her diploma to the board during the examination.

3. Both sides of the application blank must be properly filled or it will not be accepted.

4. Each applicant must attach to his application an unmounted photograph, 3x4 inches, with certificate of the photographer on the back thereof, setting forth that it is a true picture of the applicant, taken within sixty days of the date of the application. A photograph larger than 3x4 inches will positively not be accepted.

5. The minimum preliminary educational requirement is a four-year high school course, and, in addition, one year in a college of liberal arts, after January, 1914. Class "A" and "B" colleges only are recognized.

6. The regular meetings of the Board are held on the second Tuesday in February and October and the third Tuesday in June of each year, at Topeka, from 9 to 12 a.m., and 1 to 5:30 p.m., and will continue three days.

7. Candidates detected in attempting to

give or obtain aid will be instantly dismissed from the room, and his or her papers for the entire examination canceled.

RECIPROCITY.

8. Kansas reciprocates on a basis of examination only and not on diploma. Applicants for reciprocal registration, from states holding such relations with Kansas, shall make their applications on the indorsement blanks furnished by this board, and the several requirements therein fulfilled. A verbatim copy of the applicant's license must be made on the Kansas indorsement blank, under No. 7 on page 2, and the grades must appear on the same page after each subject and certified to by the secretary of the state medical board from which it is issued, and upon receipt of the application with all parts of the indorsement blank filled out, together with the reciprocal fee, which is the same as that of the state from which the applicant comes requires of Kansas licentiates for reciprocal registration in the applicant's state, a certificate to practice medicine and surgery in the State of Kansas will be issued by the Board, unless the application should be rejected for cause. Kansas does not issue a license on diploma, or on a certificate issued by any other state on diploma. It must be shown that a written examination has been passed by the applicant before a license will be issued by reciprocity. The secretary in his discretion may permit the applicant to practice until the next meeting of the board, after the application is filed with the fee.

BASIS FOR RECIPROCAL MEDICAL REGISTRATION

A certificate of registration showing that an examination has been made by the proper board of any state, on which an average of not less than seventy-five per cent was awarded, the holder thereof having been, at the time of said examination, the legal possessor of a diploma from a medical college of good standing in the state where reciprocal registration is sought, may be accepted in lieu of examination, as evidence of qualification: Provided, that in case the scope of the said

examination was less than prescribed by the state in which registration is sought, the applicant may be required to submit to a supplemental examination by the board thereof in such subjects as have not been covered.

The following states reciprocate with Kansas on a basis of examination only and the fees, viz: California, \$50; Delaware, \$50; District of Columbia, \$25; Georgia, \$50; Illinois, \$50; Indiana, \$50; Iowa, \$50; Kentucky, \$25; Louisiana, \$25; Maine, \$25; Maryland, \$25; Michigan, \$50; Minnesota, \$50; Mississippi, \$50; Missouri, \$25; Nebraska, \$25; Nevada, \$25; New Hampshire, \$25; New Jersey, \$50; New Mexico, \$25; North Dakota, \$25; Ohio, \$50; Oklahoma, \$25; Pennsylvania, \$50; South Carolina, \$25; Tennessee, \$25; Texas, \$50; Utah, \$75; Vermont, \$50; Virginia, \$25; West Virginia, \$25; Wisconsin, \$50; Wyoming, \$25.

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Kansas Hospital Association

The Kansas Hospital Association will meet at Hutchinson October 10, 1919. The following program has been arranged:

The Superb Educational Facilities of the Small Hospital Training School, Dr. G. W. Jones, Lawrence.

Hospitals, Religious, Municipal and Private, Dr. J. T. Axtell, Newton.

How Large Should a Hospital Be to Conduct a Training School? Miss E. L. Kelleher, R.N., Hutchinson.

Hospital Records, Dr. A. E. Hertzler, Halstead.

Round Table Discussion.

The Open or the Closed Staff.

Meeting called at Commercial Club room at 9 a.m.

Forenoon and afternoon session.

—————R—————

Fraudulent "Cures" for Venereal Diseases Seized

By order of the federal courts more than 450 seizures have been made recently in different parts of the United States of so-called cures for venereal diseases. They were made on information furnished by officials of the United States Department

of Agriculture through its Bureau of Chemistry. A campaign to end the false labeling of such preparations is being conducted by the officials charged with enforcing the Federal Food and Drugs Act.

The goods seized include a great variety of compounds. Some of the labels bear the claim of the manufacturer that the contents are sure cures for venereal diseases. Some even contain statements that cures will be effected within definite periods, varying from three days to a few weeks. In others indirect statements, suggestive names or deceptive devices are craftily used to make it appear that the use of the preparation will be followed by a cure of the disease.

In all the seizure actions the Government alleged the preparations to be falsely and fraudulently labeled, because the ingredients could not produce the results claimed on the labels.

The officials state that such preparations are sold largely because of plausible but false claims regarding their curative effect. Many sufferers with dangerous contagious venereal diseases are led to believe that cures will be effected by these preparations, and adequate treatment under competent medical supervision is neglected until permanent injury to health and even danger to life has resulted. Thus is created one of the greatest obstacles to the proper control and eradication by health officials of venereal diseases. In many instances had such sufferers secured competent advice, early and complete cures might have been effected.

Self-treatment with worthless concoctions causes not only continued suffering but sometimes permanent injury to the unfortunate victims and makes of them a menace to the public health because of the extreme danger of others contracting the disease from them.

Action under the Federal Food and Drugs Act in reference to venereal-disease preparations coming under its jurisdiction and sold under proprietary names is limited by the terms of the act largely to the prevention of false or fraudulent labeling.

The act does not prevent the sale of any mixture as medicine, however worthless it may be, if there is directly or indirectly no false or fraudulent labeling. The officials in charge of the enforcement of the act are of the opinion, however, that by causing the elimination of false labeling, upon which the sale of such preparations largely depends, the evils and dangers resulting from their indiscriminate use can be greatly checked, and substantial aid rendered to public health officials.

—R—

Medical Society of the Missouri Valley at Des Moines

The thirty-second annual meeting of this society will be held in Des Moines, Iowa, Thursday and Friday, September 18-19, under the presidency of Dr. Charles Wood Fassett of Kansas City. Arrangements are in the hands of the Polk County Medical Society, Drs. Charles Ryan (chairman), R. A. Weston, J. C. Rockefeller, and Fred Moore, committee.

The scientific program will cover a wide range of subjects of interest to every member, no matter in what special field he is working. One-half day will be devoted to war subjects, shell shock, hemorrhage, amputations, gas, and rehabilitation. All members who were in the service are invited to contribute to the symposium.

Hotel Fort Des Moines will be headquarters and meeting place. The commercial exhibits will also be held here. Make your room reservations early.

Program will be issued early in September and will be limited to twenty papers.

A "home-coming dinner" will be given in the evening of the first day at the Fort Des Moines Hotel, followed by addresses by men of national reputation. The profession is cordially urged to attend this dinner.

PRELIMINARY PROGRAM

Lieut.-Col. Horace Evans, M.S., U.S.A., Chief Section of Physical Reconstruction, will address us on "Work being done in reconstruction hospitals." Col. Evans is the special representative at this meeting

of Surgeon General Ireland of the U. S. Army.

Dr. Frank Smithies, Chicago, "Amnesia."

Dr. B. B. Grover, Colorado Springs, "Hyperpiesis."

Dr. E. C. Rosenow, Mayo Foundation, "Influenza."

Dr. Frank C. Norbury, Springfield, "The Mental Mechanism of War Neuroses."

Dr. John W. Shumann, Sioux City, Iowa, "Luetic Cerebrospinal Meningitis."

Dr. George H. Hoxie, Kansas City, "The Thyroid Response to Overstrain."

Dr. Clifford G. Grulee, Chicago, "The Clinical Picture of Pyelocystitis in Infancy."

Dr. H. Winnett Orr, Lincoln, Neb., "The Treatment of Spinal Curvature."

Dr. A. F. Taylor, Omaha, Neb., "The Treatment of Uterine Hemorrhage by Radio-Therapy."

Among the many delightful features planned by the entertainment committee will be a luncheon at the Commerce Club, carriage drives and a tea for the ladies, and an automobile trip to Fort Des Moines on the afternoon of the second day.

—————R—————

Annual Meeting of Medical Association of the Southwest

The fourteenth annual meeting of the Medical Association of the Southwest will be held at Oklahoma City the first week in October and it is confidently expected that this will be the greatest meeting the association has ever held. Plans for a reunion of all medical officers from these five states who have been called into active service are already well under way. This will be held on the Monday afternoon and evening before the opening session of the meeting which will be held Tuesday morning. Monday there will be a camp fire and smoker and many of the men who were over seas will be there to tell their experiences. This, so far as known at present, will be the first reunion of medical officers and the secretary of the association, Dr. Fred H. Clark, El Reno, Okla., will consider it a great favor if all officers

who have been in service will send him their names so he can keep in touch with them regarding this meeting. The program will be issued soon and a copy will be sent to every officer sending his address to Dr. Clark.

A cordial invitation is also extended to those who desire to present papers on the regular association program and they are requested to send their name and subject to the secretary at once, as the number of papers on the program will be limited and those applying first will have the preference.

Two full programs of interesting clinics will be arranged and all who were at the last meeting of the association in Oklahoma City will remember what a success the clinics were at that time and will not want to miss this. As far as can be announced there will be clinics on internal medicine assisted by the use of the X-ray; clinics on skin and especially malignant growths; genito urinary with the administration of 606, and of course full clinics on eye, ear, nose and throat and general surgery. The new state hospital will be done by that time, which will add very materially to the surgical opportunities.

Don't forget to send in your name if you are a former medical officer or if you wish to prepare a paper.

F. H. CLARK, Secretary,
El Reno, Oklahoma.

—————R—————

Asthma

G. Sluder, St. Louis (*Journal A. M. A.*, Aug. 23, 1919), says that none of the observations published seem to explain the mechanism of asthma. The question seems to present possibilities, if not of solution, at least of interesting speculation. His ideas came to him in the course of his observations on the "lower half" headache produced in sphenoidal and nasal ganglion regions. The explanation of the pain produced from the nasal ganglion necessitates to his mind, the assumption of functions on the part of the sympathetic system which cannot be proved. It must be assumed, he thinks, to explain in man the

"lower half" headache, that the nervous system has the power of transmitting under pathologic conditions afferent pain impulses from the nasal ganglion to the neck and shoulder, the present ideas of anatomists and physiologists to the contrary notwithstanding. He goes into the anatomy of the region to explain this, and says that one of the difficulties in explaining its physiology and pathology is that none of the observations have been made on man and that the experimental animals vary to a considerable extent. He refers to his personal experience in the removal of polyps, for instance, which has never been successful in relieving asthma, though others claim success. But he has been much more fortunate in the treatment of the posterior part of the nasal cavity. Considering asthma as a reflex, the question is, to his mind, one of whether or not the condition is due to irritation of the sympathetic nervous system. If the asthma reflex can be best controlled from the nasal ganglion or the sphenoid sinus, they should be the places from which it may sometimes be started experimentally, and he gives examples from his practice indicating that this is the case. Some cases of asthma were apparently of local inflammatory origin, and efforts to prove some sensitization to proteins failed. Some were acute, and some were chronic hyperplasia, without cultivation bacteria, while others, like those of the hay-fever group, were clearly sensitive. In inflammatory cases, the local lesion should be sought and cured. Sluder does not claim to answer the question of why, if the sympathetic nervous system is concerned in asthma production, there are not more evident cases of it. There may, however, be anatomic variations, which will explain some cases. As regards the question of sensitization, it cannot be answered; but it seems certain to him that there are anatomic variations in the sympathetic nervous system.

—R—

Influenzal Pneumonia

H. F. Stoll, Hartford, Conn. (*Journal A. M. A.*, Aug. 16, 1919), reports an ex-

perience with fifty-six patients with influenza pneumonia, 70 per cent in poor condition, who were treated with the blood or serum of convalescent patients, with approximately 50 per cent mortality. Twelve patients were treated within two days after development of the pneumonia; ten of these showed prompt improvement and recovered. One of the two patients in the two fatal cases had incipient empyema. Thirty-two patients had been ill for an average of 3.9 days when first treated, and 72 per cent of these showed distinct betterment. Of twenty-four who had been ill 5.4 days when treatment was given, 80 per cent of whom were seriously ill, 17 per cent showed improvement. Nine patients, six of them seriously ill, were treated with blood or serum from patients convalescent from influenza but not pneumonia, and only two showed marked improvements, both reacting with chill. Nineteen patients received transfusions of blood or serum from individuals who had not had influenza or pneumonia. The results were the same whether the prognosis was good or bad, 20 per cent seemingly benefitted. Nine patients were given blood or serum from healthy adults, vaccinated beforehand with triple pneumonia vaccine. In only one instance, in a case of lobar pneumonia with leukocytosis, did improvement follow. Sixteen per cent of all the patients treated with convalescent serum reacted with a chill and rise of temperature. Prompt improvement followed this reaction in all but four instances. In four patients critically ill, possibly death was hastened by the reaction. "In 80 per cent of the cases in which definite improvement was shown, no reaction was manifest. Over half of the patients showing improvement required only one injection to obtain the desired results." Stoll concludes that transfusion of "normal" blood or serum is only exceptionally of value in influenza pneumonia, and that the blood from individuals vaccinated against pneumococcus Types I, II, and III is no better in this type. The impression received from the few patients with con-

valescent serum was that it was less potent than convalescent pneumonia serum, but more so than "normal" serum. Transfusion of blood or serum from convalescent pneumonia patients is occasionally of value as late as the fifth day of the disease, and when used early within the first three days, most cases show distinct improvement. It seems to lower the mortality and shortens the course of the disease and complications are fewer. It seems, therefore, to have definite value as a therapeutic agent.

R

Influenza

No drug, says J. B. Herrick, Chicago (Journal A. M. A., August 16, 1919), is known that will prevent the occurrence of influenza. Some have been tried, but the reports of optimistic physicians in regard to them do not convince. Segregation of cases will prevent contact infection, or it might be better said that such measures lessen the spread of the disease by lessening the concentration of exposure. Observing the incidence of influenza, as it occurred in the camps and larger towns, it seems as though the epidemic goes through the populace, sparing the immunes, but affecting the susceptibles, approximately 30 per cent of the whole number. Reports of clinical observations and experiments vary as regards the value of the gauze masks, though they undoubtedly may prevent droplet infection. If wrongly made or used when soiled, they may have the opposite effect. Nevertheless, they have come to stay; but the failure of attempts to transfer influenza by swabbing the throats of healthy individuals with the nose and throat secretions of diseased persons shakes our faith in the value of the mask's use as a preventive measure. To convince one of the fact that there is no accepted method of treatment, it is only necessary to see cases in consultation or read the literature of the epidemic. There is one feature, however, on which all agree, and that is the importance of early rest in bed, continuing it until fever, cough and other symptoms have been absent for sev-

eral days. A few days more of the period of rest would often save the patient from a protracted convalescence or serious sequels. A sunlit room, plenty of fresh air, a light diet and a liberal amount of liquids should be allowed and the bowels kept freely open. It is hard to refrain from using drugs because the diagnosis has been made. A level-headed physician may be, as it were, overwhelmed by the hysterical atmosphere as regards the possible grave consequences. In Herrick's experience, the most valuable drug seemed to be digitalis, given by mouth, subcutaneously or intravenously, and he thinks in some cases he has seen heart failure averted by its use, and has never seen any harm from its careful employment. Next to digitalis, he ranks opium, and, in an asthmatic patient, with wheezing chest, he observed good results from using epinephrin. Hypodermoclysis or proctoclysis may be helpful, and he thinks he saved one life by bleeding. One should not be a nihilist in the treatment of this disease, but how much harm may be done by overdrugging no one can estimate. The danger is a real one.

R

S. S. S.

The State of Louisiana has a law prohibiting the sale of venereal disease remedies, except on the written prescription of a licensed physician. In May of this year the Bureau of Venereal Diseases of the Louisiana State Board of Health notified the druggists of Louisiana that the sale of "S. S. S." ("Swift's Syphilitic Specific" or "Swift's Sure Specific") would meet with the same law enforcement measures as were being waged against any venereal disease nostrum. The result of this notice was a letter sent to various drug stores of Louisiana by the sales manager of the Swift Specific Company declaring that "S. S. S." is not recommended or advertised as a venereal medicine. A few years ago "S. S. S." was boldly heralded in newspaper advertisements as a "cure" for syphilis. (Jour. A. M. A., August 30, 1919, p. 707.)

In Many a Hurry Call

The doctor will find Thromboplastin solution (Armour) a most convenient thing to have in his case. It is a specific hemostatic and acts promptly.



Thromboplastin Solution (*Armour*)

is made from the brains of kosher-killed cattle and is standardized physiologically on oxalated blood, is guaranteed to be of full therapeutic strength and is sold in dated packages—25 c.c. vials.

Pituitary Liquid (*Armour*)

is the physiologically standardized solution of Posterior Pituitary and is absolutely free from chemical preservatives.

A small dose is suggested for obstetrical work— $\frac{1}{2}$ c.c. ampoules. Boxes of 6.

For surgical work 1 c.c. ampoules. Boxes of 6.

As manufacturers of the endocrine gland and other organo-therapeutic agents our facilities are at the service of the medical profession.

Armour's Sterilized Catgut Ligatures are offered in standard (60 inch) and emergency lengths (20 inch) plain and chromic.

ARMOUR AND COMPANY
CHICAGO

Grandview Sanitarium

KANSAS CITY, KANSAS

The Grandview Sanitarium was completely destroyed by fire; Fifteen years active work in the sanitarium business enabled us to know our needs for the future. We have planned, built and completed what we believe to be an ideal place and are open and ready for business. Thanking our friends for their patronage in the past and assuring you we are prepared to give as good service as can be had in any sanitarium, we remain,

Very truly yours,

S. S. GLASSCOCK, M.D., Res. Supt.

A. L. LUDWICK, A.M., M.D., Asst. Supt.

EDITH GLASSCOCK, B.S.

Business Manager

Office 910 Rialto Bldg., Kansas City, Mo.

The Merry Optical Company Opens Surgical Department

While the specialists' store is not a new idea, there being several in the east, it is new for the middle west and will no doubt be hailed with great enthusiasm by those engaged in the practice of eye, ear, nose and throat surgery, as this will eliminate the sending east for items formerly not obtainable in the home territory.

The Merry Optical Company plans to carry a complete line of all instruments for this work, also the enamelware, furniture and dressings; in fact this stock will comprise everything used by the specialists.

High grade instruments of the best patterns obtainable, coupled with the usual Merry service, will make this department one of the greatest assistance and convenience to the progressive surgeon.

Mr. E. C. Davis, who has been for several years associated with the surgical instrument business in this territory, will be in charge of this department and will be glad to welcome old friends and to make new ones.

—R—

Dr. Abraham Jacobi.

With Dr. Jacobi's passing, medicine loses one of its foremost figures. Dr. Jacobi enjoyed an unusually long and eventful career, marked by numerous honors at the hands of civic and professional societies. In his capacity as teacher and writer for six decades, he was known to a vast number of physicians throughout the country. His conversation and writings were full of "quaint wit, varied learning and true wisdom." His interest in medical progress and medical knowledge never wavered. Justly held in touching reverence by American physicians, Abraham Jacobi, the Nestor of American pediatrics, lived a full life as beloved physician, noted pediatrician, public spirited citizen, and honored leader.

—Jour A. M. A., July 19, 1919.

—R—

The violent poison found in the cigaret paper is acrolein.



Quaker Oats vs. Whole Wheat

Quaker Oats compares with whole-wheat flour as follows:

In calory value oats excel by about 10 per cent.

In protein by about 30 per cent.

In fat by about 400 per cent.

In minerals by about 200 per cent.

As compared with lean beef—with round steak—oats have twice the calory value. They have about three times the mineral value. The protein difference is about 15 per cent.

Meats, on the average, cost ten times Quaker Oats for the same calory value. And meats cannot compare with Quaker Oats as food.

Quaker Oats

Queen Grains Only

Quaker Oats is flaked from queen grains only—just the rich, plump, flavy oats. The puny grains are all discarded, so we get but ten pounds from a bushel.

The result shows in that matchless flavor. It has won oat lovers all the world over to this delightful brand. Yet Quaker Oats are obtained for the asking, without any extra price.

The Quaker Oats Company

Chicago

3172

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Potential and Acquired Static Flat Foot

By EDWARD H. OCHSNER, B. S., M. D., F.
A. C. S., Attending Surgeon, Augus-
tana Hospital, Chicago.

Read at the Annual Meeting of the Kansas Medical Society
held at Ottawa, Kansas, May 7 and 8, 1919.

The subject for consideration to-day was chosen for a number of reasons. First, because of its prevalence. Second, because of what I consider an increasing prevalence, and finally, because we have to-day at our disposal, a very simple method of not only relieving the symptoms of flat foot, but of anatomically curing the condition. These may sound like strong statements, but I believe that by the time you reach the end of this paper you will agree that they are substantially correct.

Some twenty years ago I became interested in the subject of flat foot. I made a rather long and painstaking study of it. Among the statistics on flat foot, I found, for instance, in Munson's¹ work on Military Hygiene, the statement that out of 9,901 members of the Illinois National Guard, who offered themselves for the United States service in 1898, 33, or 3.3 per thousand were rejected because of excessive or painful flat foot. All of these had previously passed the physical examination required to enter the State Militia. A few years later I wrote a letter to the Surgeon General's Office and obtained the following statistics: During the years 1903, 1904 and 1905, 132,145 men were examined for the United States Army. Of this number 457, or 3.4 per

thousand, were rejected because of excessive flat foot. Anyone who has been engaged in examining men for the National Army in the recent draft knows that either one of two things has happened, either the figures above given were too low as an average even twenty years ago, or flat foot has increased alarmingly since then. I think both are a fact. I believe that the figures were too low even for that period because only reasonably able-bodied men offered themselves for the army, and I believe that flat foot has increased tremendously in the last twenty years and is still on the increase and later I will try to explain what produces not only the prevalence, but the ever increasing prevalence.

In support of the fact that the number of cases of flat foot are enormously greater than the figures I have given you we have certain evidence. I served on the Medical Advisory Board for Chicago and vicinity and it seemed to me that every second or third man that came to me for examination had flat feet. We got the border-line cases, to be true. However, other examiners have told me exactly the same thing, namely, that they were astonished at the prevalence of flat foot among registrants. We also have some definite statistics in regard to this matter. These were taken from what I consider an absolutely reliable source.² Examinations of the records of 72,410 men for the service of the United States Navy for 1914 shows 76% were rejected. Of the total number rejected, 10.77 per cent were rejected for

¹ Munson: Military Hygiene, page 32.

² "Sickness Insurance or Sickness Prevention." National Industrial Conference Board. Research Report No. 6. May, 1918.

flatfoot. Or, in other words 8.22 per cent of the total number examined were rejected for this condition. This is thirty-one times as large a rejection as in 1898, and 1903-1905. It must not be forgotten, however, that previous to our entrance into the war, the Navy was exceedingly rigid in its physical examinations. When the complete statistics of the present war are available we will, I believe, find further statistical evidence of not only the great prevalence of this affection but also of the statement that flat foot has increased astonishingly during the past two decades, even though we must admit that a part of the apparent increase is due to better diagnosis.

One reason why so many mistakes have been made in the diagnosis of this condition in the past is to be found in the faulty nomenclature which has been employed. None of the terms, such as flat foot, weak foot, splay foot, pes valgus, or pes flexus pronatus reflexus of Henke, adequately express the condition. I, therefore, some 12 years ago, in a published article, introduced the word potential, calling the whole symptom-complex potential and acquired static flat foot. The former, the transition stage from the normal to the latter is the most often overlooked and yet many times the more painful and incapacitating, and the stage in which treatment is most effective and a cure most rapidly accomplished.

Definition

Potential flat foot is a weakened condition of the arch due to a disproportion existing between the strength of the foot and the strain to which it is exposed, in which the strain has not been severe enough to break the arch. Acquired static flat foot is an acquired compound deformity in which the foot assumes an abnormal relation to the leg and the bones of the foot abnormal relations to each other. This results in improper distribution of weight and strain, abnormal function and loss of arch.

In order that treatment may be uniform successful in both types of cases

it is absolutely essential that the physician in charge of the case keep constantly in mind certain fundamental facts in reference to the anatomy, pathology, etiology and symptomatology of this condition.

Anatomy and Pathology

The normal shape of the foot is maintained by three distinct factors. First, the shape of the bones, second, the ligaments and fascia and finally the muscles. If a disproportion exists between the weight which is borne and the strength of all of these three factors, the longitudinal arch must give and flat foot must result. The first one to suffer in the development of flat foot is usually the muscles. The ligaments and fascia come next and deformity of the bones last. General muscular weakness predisposes to flat foot, but the tibialis anticus and the tibialis posticus are the two muscles most involved in this condition. If they become weakened or over-stretched, the foot is abducted and everted, the weight of the body is then borne not on the center of the arch, but internally to it and the arch is put to a very great mechanical disadvantage with the result that in extreme cases the relation of the tarsal bones to each other is markedly changed and even their very shapes ultimately become altered.

Etiology

Etiology of this condition may be divided into three main classes. First, relative weakness of the muscles. Second, excessive weight bearing. Third, anything which has a tendency to disturb the proper relation of the bones to each other, such as faulty attitudes and faulty footwear. Anything which causes relative weakness of the muscles, particularly of the tibialis anticus and posticus predisposes to flat foot. Among the most common causes which produce weakness of the muscles may be mentioned, acute and chronic diseases and puberty. It is interesting to note that if the flat foot histories are carefully taken, a large majority of these patients refer their flat foot pains to about the age of puberty. Thus, Royal

Whitman³ says, 57.3 per cent first come to the physician between ten and twenty-five years of age. Hoffa⁴ says, 61.6 per cent between eleven and twenty-five years, while the same author gives 50.7 per cent between sixteen and twenty-five years of age. What per cent of those who come for treatment later developed the symptoms shortly after puberty I have been unable to glean from the literature, but in my experience at least, the great majority state that their first symptoms occurred about or shortly after puberty. F. Peterson⁵ explains this fact by the observation that the body constantly gets heavier at this time, the muscles stretch out but do not get correspondingly thicker. Stanley Hall⁶ says, virtually the same thing, when he makes the statement that during puberty the different structures grow with different degrees of rapidity causing a temporary increase in weight without corresponding muscle strength. Unfortunately, at just about this period in life many of our young people leave school, begin their life work which often entails excessive weight bearing and excessive fatigue and it is no wonder that they at this time lay the foundation for a condition, which, if not vigorously combated, may impair their usefulness for life. Beginning of the breaking of the arch usually causes a great deal of pain. The patient in order to get away from his pain assumes the "attitude of rest" so well described by Annandale. This throws excessive strain on the fascia and ligaments, which is followed by their stretching causing a subluxation of the bones with a change of their axis and weight bearing surfaces, which must sooner or later result in the change of their shape. Another factor which aids in producing this result is faulty footwear. More particularly the shoes, though even the stockings often play an important role in the production of flat foot. This was very well brought

out by John A. Sampson.⁷ Since his excellent paper was written many orthopedists have devoted considerable thought and attention to securing proper footwear, but unfortunately their work has not borne much fruit in so far as preventing the mass of the people from being compelled to wear ill-fitting shoes. The shoemakers, as a general rule, both custom and factory, are much more concerned about bringing out a new style of shoe which will result in large sales than in making a shoe which actually fits the foot and which will give the wearer the greatest comfort and efficiency. The shoemakers seem to forget that space has three dimensions and in the manufacture of shoes they actually consider only two, namely, length and breadth. Thus, if a lady buys a 5-B shoe, she gets a size which represents a definite length and a definite width, but which pays no attention to the third dimension, height. As a result, many people who start out with excellent insteps soon suffer from foot trouble because constant pressure is made on the instep from a shoe that is too small at this point. This pressure abducts and everts the foot and if the pressure is allowed to continue long enough, breaking of the arch must follow. This fault is illustrated in figure No. 1, which is a schematic drawing of the relative size and shape of an actual shoe and the cast of a foot upon which the shoe has been worn for many months. This shows to what a needless strain this foot had been placed for a long time. Physicians tell us that action and reaction are equal and in opposite directions. Feet, which, year after year have to break in shoes which are too low over the instep will sooner or later be themselves broken at this point. Then, to make the bad condition worse, along comes the shoemaker with his cure-all arch supports. While arch supporters sometime relieve flat foot pains they never cure flat foot simply because they relieve the tibialis anticus and

³ A Treatise on Orthopedic Surgery.

⁴ Orthopaedische Chirurgie, 1902.

⁵ Zum Mechanismus des Platt Fusses, Arch. klin,

⁶ Psychology of Puberty.

⁷ Proper Foot-wear and the Treatment of Weakened and Flat Feet by Mechanical Devices for Maintaining the Adducted Position.

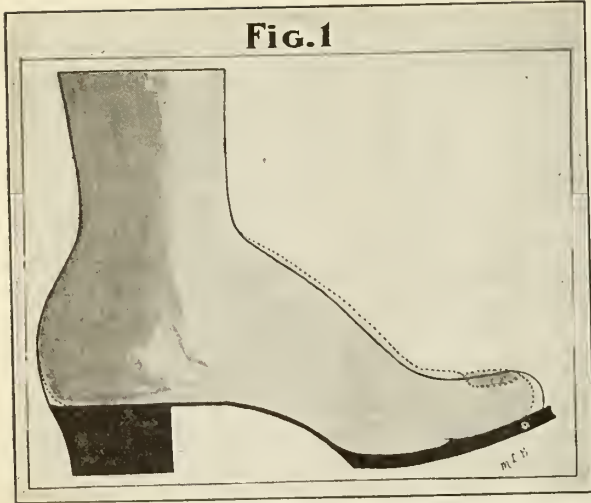


Figure I. Illustrates common disproportion in foot and shoe. Dotted line, outline of foot; solid line, outline of shoe.

posticus muscles from all function, thus causing still further atrophy of those muscles, and in addition they have a tendency to accentuate the faulty position by favoring abduction and eversion. If arch supporters are worn before flat foot has developed, they have a tendency to actually produce flat foot and the common wearing of arch supporters is, I believe, the principal reason why flat foot is so on the increase. There is a commercial reason why arch supporters are so commonly worn. Some months ago I had occasion to step into one of our large shoe stores to see the manager on some business. While waiting for this gentleman fifteen minutes I spent the time critically watching the shoe salesman. Practically every time when the salesman had sold a pair of shoes, he suggested to the customer that he ought to wear arch supports. In a very considerable per cent of the cases the customer was actually persuaded to purchase them. When the manager finally arrived and my business with him was finished, I casually remarked that I observed that his salesmen were selling a large number of arch supports and asked him why they were doing it. He looked at me rather sheepishly and answered that as a matter of fact their profit on arch supports was nearly as large as on shoes,

and that the capital invested was much less and as a rule it took much less time to sell a pair of arch supports than a pair of shoes. The whole matter was evidently on a purely commercial basis, caring little or nothing for the welfare of the customers. I understand that this is a prevailing custom in most of our large shoe stores. If so, it will be absolutely necessary to educate our people and teach them the baneful effect of arch supports, otherwise, our American public is going to suffer more and more from flat foot. The first thing that will be necessary, however, is to educate our orthopedic surgeons not to prescribe arch supports, for as long as they continue to do this, the practice will have a standing in court, and shoe salesmen a legitimate excuse.

Symptomatology

Some of the first symptoms that the patient complains of in the development of flat foot are cyanosis, coldness, numbness, sweating of the feet, fatigue on the slightest exertion and general ill-defined discomfort. These symptoms are not only the first to develop, but often the first to disappear when the proper treatment is instituted. The first and never failing sign is an outward deflection of the tendo Achillis, a sign first described by Helbing.⁸ If the patient is directed to stand on an elevated platform with his back toward the examiner, this sign will be found in every case of flat foot, even in its earliest incipency, as I illustrated in Fig. II. Another early sign, is the tendency these patients have to assume the "attitude of rest," so well described by the great English surgeon Annandale. This attitude is assumed unconsciously in the hope of relieving the tired muscles and throwing the strain upon the bones and ligaments. The oftener it is assumed, the more pronounced will become the peculiar abduction and eversion of the foot with the ultimate breaking of the arch, as illustrated by the flat foot imprints. Well-made imprints of the sole of the foot are sometimes of help

⁸ Aus dem Gebieten der Ortho. Chir., March 27, 1905, p. 368.



Fig. 2

Figure II. Illustrates Helbing's sign, showing lateral deflection of left tendo Achillis one of the first signs of flat foot.

in making a diagnosis and always of interest in watching the progress of the condition, but we must not forget that there is no direct relation between the sinking in of the arch and the severity of the symptoms or the degree of disability. A beginning flat foot may be so painful as to utterly incapacitate the patient from all work and yet show no loss of arch. We must ever remember that "flat foot is a compound deformity in which the abnormal relation in foot and leg, causing the improper distribution of weight and strain and disuse of normal function, is of vastly greater importance than the depression of the arch which has given the name to the disability."⁹ A copy of the now classic Volkmann flat foot imprints is introduced here, Fig. III., not so much for the purpose of urging its use in making a diagnosis of the condition as to emphasize what has just been said, namely, that a beginning flat foot such as would

make imprint B, may be much more painful than a fully developed flat foot such as would make imprint D, or even a potential flat foot, the imprint of which may not differ in the least from the normal imprint A, may cause much more discomfort than a fully developed flat foot, imprint D. The making of flat foot imprints is especially urged because it will demonstrate as nothing else can, the progressive improvement in the condition as the treatment continues.

If the factors producing the tendency to flat foot are not relieved the fatigue and discomfort above alluded to will become actual pain. The pain can usually be analyzed as occurring in one or more of the following seven places, namely:

(a) Where the tuberosity of the scaphoid and the head of the astragalus make pressure on the calcaneo scaphoid ligament. In severe cases, a bursa may even form here, which may become inflamed and even suppurate and the pain at this point may become excruciating.

(b) Mid-dorsum of the foot where scaphoid impinges on the neck of the astragalus.

(c) On the outer surface of the foot where, because of the rotation, the external malleolus rubs against the astragalus.

(d) Planter surface of heel. This point of pain has often been mistaken for a gonorrheal periostitis. While gonorrheal periostitis has occurred here occasionally,



Figure III. Illustrates reproduction of Volkmann's flat foot imprints showing: (a) Imprint of normal foot; (b) Beginning flat foot; (c and d) Terminal conditions.

⁹ A Treatise on Orthopedic Surgery.

the pain at this point is much more frequently due to flat foot than to gonorrhea.

(e) At metatarso-phalangeal junction or Morton's pain, because we sometimes have the breaking of the longitudinal arch complicated by a breaking of the transverse arch.

(f) Pain in thighs, hips and back. Not infrequently, these flat foot lumbar pains are wrongly diagnosed and unsuccessfully treated as lumbago.

(g) Calf pains due to spasm of calf muscles.

I have repeatedly had patients come into my office with crutches and canes, who have been unable to follow their vocations in life for months and even years, who, on careful examination were suffering from nothing more serious than flat foot.

These pains as well as the changed relations of the bones of the lower extremity result in a peculiar gait of the flat foot patient. In the early potential cases, the patient usually walks gingerly as though his shoes hurt him. In the later cases when the feet are markedly everted and abducted and the muscles spastic, the patient acquires a very peculiar gait utterly lacking in elasticity, with his feet held rigid and all of the motion taking place in the knees and hips.

Treatment

The treatment can be taken up under two main headings, Prophylactic and Curative. With this proviso that the prophylactic measures practically all come under the curative remedies also. As in many other medical problems, prophylaxis is the most important and if people were better informed about prophylaxis, the treatment of flat foot would rarely become necessary.

In order to prevent the development of flat foot, the general hygiene must, of course, be looked after. Alternate periods of exercises and rest must be provided. Excessive strain, such as excessive weight bearing or long continued standing in a faulty attitude must be avoided, especially at the age of puberty or after an acute or

debilitating illness. Obesity, if existing, should be corrected. All persons should be taught how to stand and walk properly, proper shoes should be provided and arch supporters should be absolutely tabooed. As stated above, improper standing and walking has much to do with the development of flat foot. Hence, every school child should be taught how to stand and walk and every flat foot patient must learn how to walk and stand properly if they are to recover. There is a false idea prevalent that toeing out is graceful. This common belief has its origin to a large extent, I believe, in the old Infantry Drill Regulations of the United States Army, which read, "the recruit at attention must stand with his feet turned out equally and forming with each other an angle of about sixty degrees." I am informed that recent Infantry Drill Regulations conform to a suggestion which I made twelve years ago in a published paper on this subject, namely, "that the recruit at attention stand with his feet turned out equally and forming with each other an angle not to exceed sixty degrees." This gives the soldier a chance to use his feet to the best mechanical advantage. The old drill regulations unquestionably favored abduction, eversion and faulty weight bearing, which, if persisted in is almost sure to produce flat foot. In addition, people should be advised to walk with their feet parallel. I have watched very carefully and so far have never come across a patient suffering from flat foot who habitually stood and walked with his feet nearly parallel. Recently, I asked a very intelligent, observing, highly educated layman, who had spent many years as a buffalo hunter among the Indians, whether he had ever seen an Indian with flat feet and he very promptly answered, "no." I followed the first question by the word, "why," and he promptly answered, "because they do not wear shoes and because they walk with their feet parallel."

This brings me naturally to the question of footwear. Stockings that are either too short or too tight over the instep

should be scrupulously avoided. Shoes should fulfill the following requirements. They must have the proper length, the proper width and the proper height over the instep, and the treading surface must be ample in order that the circulation of all of the structures of the foot may not be impaired and that the foot muscles may have sufficient room for exercise. The internal border should be a straight line, the widest part of the shoe should correspond with the widest part of the foot, namely, the ball. The heel should be placed slightly forward and inward as illustrated in Fig. IV. Finally, the shoe should be as com-

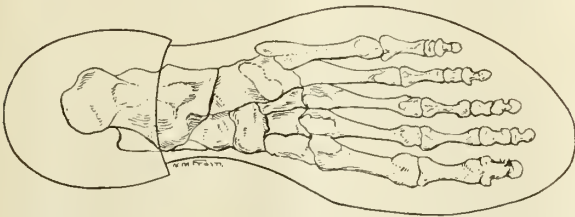


Figure IV. Illustrates proper shape of shoe.

fortable the first day it is worn as the day it is discarded. About the only way to get such a shoe is to have one made from one's own private special last, made after a Plaster-of-Paris model of the foot with the foot held in slight adduction and supination. The extra original expense is slight and the money expended for this purpose well invested, because such shoes will wear nearly twice as long as shoes which do not fit. If a new shoe has to be broken in it not only wears out much quicker, but at the same time breaks the foot. I hope the time will come when a well-dressed man will no more think of buying custom-made shoes than of going to a department store and buying a suit of ready-made clothes. Well-fitting shoes mean much more to his health and efficiency than well-fitting clothes.

When a flat foot has actually developed, the treatment just outlined must be supplemented by still further remedies, one of the most important of which is, suitable physical exercises which will improve the general muscular development and especially the development of the tibialis anticus

and posticus muscles. This can best be accomplished by prescribing properly selected definite physical exercises. Simply telling the patient to take more exercise is about as useless as telling him to take medicine. Unless the direction is definite as to the kind and amount, the patient makes a few unsuccessful attempts and then gives up in despair. If the directions are exact, I have found the patient very willing and glad to follow them to the letter, more especially as they soon experience great benefit from them. For this purpose I published a little book entitled, "Physical Exercises for Invalids and Convalescents," by C. V. Mosgy & Co., which I have found very helpful in my work with these patients. In addition, I direct them to take the following exercises, first recommended by Hoffa, I believe, five times in the morning and five times in the evening. With bare or stocking feet, sitting in a chair, the knee half flexed, have them go through the following motion with each foot, in, up, out, down, with the emphasis on the In and the Up.

I now wish to call special attention to the method of strapping, which I have used in all my cases during the past twenty-one years. I go into considerable detail as I am thoroughly convinced that the success of the method depends very largely upon the accuracy with which these directions are followed. The directions have but one object and that is to use the adhesive plaster to the greatest advantage. A system of strapping which utilizes, say ninety-five per cent of the adhesive quality of the plaster is many times more effective than a method which utilizes only seventy-five per cent.

First, I select a good make of zinc oxide adhesive plaster in twelve inch rolls. I then measure the patient's leg and mark off the adhesive straps according to the length of the extremity. For the purpose of strapping an adult male patient's foot of ordinary size, I mark off seven strips 1-2 inch wide by 32 inches long with a cross-line at the middle, fourteen strips 1-2 inch wide by 8 inches long, one strip



Figure V. Illustrates the method of marking the adhesive plaster preparatory to strapping.

1-2 inch wide by 16 inches long, as illustrated on Fig. 5. I do this as a matter of convenience and also to prevent unnecessary handling of the plaster after the facing is once removed. Plaster can easily be robbed of one-half of its adhesive strength by handling it a few times with perspiring, oily hands or by sticking it onto a dusty wall or by allowing it to come in contact with particles of cotton. Having the strips only 1-2 inch wide is a great importance. Many men fail because they use the adhesive strips too wide.

The heel of the patient's disrobed foot is now placed on a chair, the knee flexed and with a short hard roller bandage looped around the foot I direct the patient to draw the toes upward, thus placing the foot at a little less than a right angle to the leg, at the same time having it moderately inverted and adducted, as illustrated in Fig. 6. I find, that as a rule, the patient

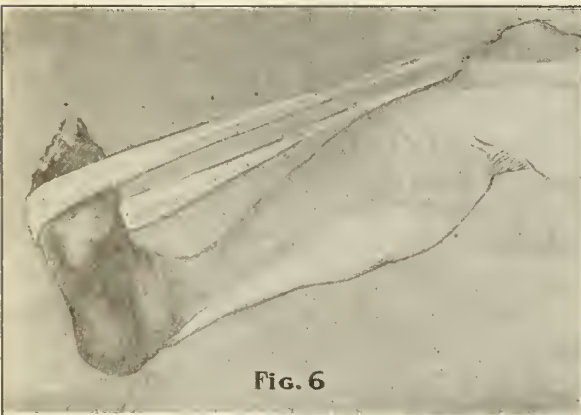


Fig. 6

Figure VI. Illustrates method of holding foot during strapping.

himself can do this much better than any assistant. Sometimes it is desirable to have an assistant grasp the foot and help the patient invert and adduct it.

I now place the middle of a thirty-two by one-half inch strap over the bottom of the heel about one inch from its posterior border, place one-half up the outer surface of the leg without tension and the other half up the inner surface of the leg applying this as taut as I can. I then place one of the short, narrow straps on the inner surface of the foot parallel with the sole and one on the outer surface. The remaining long and short straps are now applied alternately in the same manner, each one slightly over-lapping its predecessor, as illustrated in Fig. 7. When these are all



Figure VII. Illustrates method of applying long and short 1-2 inch strap.

in place, I cover them with transverse straps 3 1-4 inches wide beginning at the top and over-lapping about a quarter, as illustrated in Fig. 8. I am very careful, however, not to permit these transverse straps to meet posteriorly. On a number of occasions I have seen surgeons strap flat feet ostensibly according to my plan but completely defeating their object by putting the transverse straps circularly around the limb, thus, frustrating the purpose of the whole procedure, namely, a regeneration of the tibialis anticus and posticus muscles. These straps will remain in place and be effective for from four to eight weeks when they may be removed in the evening either with benzine



Figure VIII. Illustrates method of applying transfer straps.

or with cold cream, the foot washed with soap and warm water, carefully dried, and restrapped the next morning. This can be repeated until a cure is obtained, which may require from two to ten strappings. The relief is almost immediate, and many a patient has returned for a second strapping already relieved of many of his symptoms.

Prognosis

Though never fatal it causes much discomfort, frequently considerable pain and often not a little incapacity varying in degree from slight temporary functional impairment to more or less permanent disability, however, by following the treatment above outlined, a symptomatic cure may be expected in every case and even an anatomic cure in a very large per cent of the cases. In over twenty-one years of experience with this method of treatment I can say that I have never failed to relieve a patient if the treatment has been persisted in for a reasonable length of time and because the patients get such great relief from the treatment from the very first they are practically all willing to adhere to the treatment until they are cured. Many of these patients actually develop a normal instep, as illustrated in Fig. 9. Just exactly how the adhesive

straps accomplish this is a little difficult to say. They undoubtedly support the arch as can be easily demonstrated by applying them to a case of marked flat foot.



Figure IX. Illustrates re-establishment of arch. Upper imprints taken before treatment was begun. Lower imprints of same feet taken after straps had been worn three months.

If properly applied, they tend to supinate and adduct the foot. They relax the peronei muscles, thus, over-coming spasm, securing rest, and relieving pain. They furnish massage to the extremity with every step and consequently favor the regeneration of the muscles and ligaments. They furnish this massage continuously without expense to the patient, and we know that properly given massage is one of the most valuable remedies in restoring tone to over-tired, over-stretched, atrophied muscles.

This in brief, is the argument and evidence in favor of the treatment above outlined, a method of treatment which has given excellent results in my hands, which I consider simpler and more effective than any other method heretofore employed.

—————R—————

DEHYDRATED MEAT

The new process of dehydrating meat, it is claimed, does not coagulate the protein and thus render the meat unpalatable. The water is all removed and the product is rendered sterile and can be kept indefinitely.

The Acute Abdomen

W. E. MOWERY, M. D., Salina, Kansas

Read at the Annual Meeting of the Kansas Medical Society held at Ottawa, Kansas, May 7 and 8, 1919.

The symptoms are pathological changes found in the acute abdomen may result from injury or the sudden onset of some primary disease, or from a sudden change in some condition which may be more or less chronic, and may be classified as resulting from one of five conditions.

1. In order of their frequency from infections and inflammatory changes.
2. Foreign bodies and new growths.
3. Misplacements and torsions.
4. Interference with the nerve or blood supply.
5. Injuries.

The conditions found under the first classification, of infections and inflammatory changes, are: Appendicitis, cholecystitis, choledochitis, diverticulitis (Meckle's and colonic) pancreatitis, ulcerations (gastric, duodenal and typhoid), abscesses (hepatic, pancreatic, splenic, phrenic lymphatic glands and in the wall or mesentery of the gut), peritonitis, especially tubercular, pelvic cellulitis, gastric crisis of tabes and acute gastritis.

The conditions found under our second classification, of foreign bodies and new growths, are: Renal and hepatic calculi, interoliths, impactions, worms and hydatid cysts, foreign bodies (which have been swallowed or introduced through the rectum), sarcoma, carcinoma, cysts, fibroma, polypi, hypernephroma, hydronephrosis, cicatricial bands or adhesions, ectopic gestation, and mechanical obstruction.

The conditions found under our third classification, of misplacements and torsions, are: Hernias, volvulus, intussusceptions, torsion of the omentum, floating kidney, torsion of cysts or fibroids, and mechanical obstruction.

The conditions found under the fourth classification, of interference with the nerve or blood supply, are: Adynamic or dynamic ileus, dilatation of the stomach, infarcts, emboli or thrombosis and hemorrhage.

The conditions found under the fifth classification, of injury, vary according to the injury received. The acute pathological changes and resulting symptoms are so closely related and overlap to such a degree that they may be a part of the same process in any or all of the classifications. It is, therefore, necessary to study them somewhat in detail under each classification, and at the same time make allowance for their overlapping.

Acute infection any place in the body always produces three cardinal symptoms: pain, elevation of temperature, and leukocytosis, and when the infection occurs in the abdomen, three other cardinal symptoms can be added. They are: Vomiting, muscular rigidity and tenderness. The presence of these six cardinal symptoms, their severity, the relation of their onset and their persistence, coupled with the history of the case together with a careful physical examination, will usually lead to the correct diagnosis.

The first symptom of appendicitis and diverticulitis is pain, sudden in onset, quite severe, at first diffuse, but soon becomes localized. The pain does not entirely remit, but may be described as wavy in character.

The second symptom usually, but not always present, is vomiting, is not very profuse, and never continues to be repeated more than three or four times in an uncomplicated case.

The third symptom is muscular rigidity, at first somewhat generalized, which becomes localized within a few hours.

The fourth symptom is tenderness, quite frequently elicited over some remote part of the abdomen, but becomes localized over the infected organ within a short time.

The fifth symptom is a slight elevation of temperature which is always present during some stage of the disease, and should be taken per rectum in order that it does not pass unnoticed.

The sixth symptom is leukocytosis, which is usually quite marked and of the polynuclear variety.

The first symptom of a perforating ulcer is also pain, which is sudden in onset, but it is more severe than the pain of appendicitis. It is the most painful and persistent of any acute abdominal condition, and does not become localized early. The vomiting, while not always present, is frequently more vigorous and persistent than the vomiting of appendicitis. The muscular rigidity is greater and more extensive, and masks to a certain degree the tenderness. The tenderness remains more or less generalized, and the patient may be more tender over some remote organ than he is directly over the affected organ. The patient assumes a rather characteristic posture, and will not move or permit you to move him from this particular position. The temperature is normal or subnormal at the onset, and the patient may show signs of collapse. There is no leukocytosis until later, when the peritoneum has become inflamed there is both a rise of temperature and leukocytosis. The pulse is frequently found to be very slow in the early stages of perforation, and coupled with the foregoing symptoms, is a very valuable finding.

The symptoms of pancreatitis simulate a perforated gastric ulcer so closely that it is sometimes impossible to draw a line between the two before the abdomen is opened. However, in pancreatitis, vomiting is more profuse and frequently the patient vomits a large amount of blood. On opening the abdomen, there are spots of fatty necrosis found in the omentum.

The symptoms of abscess formation in a place in the abdomen are more gradual in onset. The temperature is the most constant symptom and is irregular; pain is usually not very severe and sometimes conspicuous by its absence. Palpation and thorough X-ray examination will usually locate the trouble. In pyonephrosis ureteral catheterization is a very valuable diagnostic procedure. Tubercular peritonitis is gradual in its onset, produces slight temperature and no leukocytosis. Its most attractive symptom is the accumulation of large quantities of acitis. Salpyngitis

and pelvic cellulitis are perhaps more easily diagnosed than any of the other conditions. They are usually the result of gonorrhea or miscarriage; are accompanied by profuse vaginal discharge, and are easily palpated on examination.

Cholecystitis and choledochitis do not produce marked acute symptoms unless they are accompanied by stones.

Gastritis is mentioned only as a matter of thoroughness and produces no difficulties in diagnosis. Gastric crisis of tabes is not to be feared so much as a dangerous condition as it is to be feared from its cunning ability to lure the surgeon into useless abdominal operation, when it should have been diagnosed instead of operated.

Foreign bodies produce their acute symptoms only when some sudden change has taken place within them or in their surroundings. Hepatic and renal calculi become acutely symptomatic, and there is an effort on the part of nature to expell them.

The symptoms of gall stones are frequently confused with appendicitis or perforating ulcer. The first symptom like the other two conditions is pain. It is intermittent in character, more severe than appendicitis, and approaches the pain of perforation, but the pain of a perforation occurs only once. There is not a history of previous attacks, as is most frequently the case with gall stones. In gall stone colic, the patient is suddenly seized with paroxysms of pain which may last from a few minutes to several hours, feels a little tired and sore after the attack has subsided, may run a little temperature, but is usually back at work the next day, which is entirely different from either appendicitis or perforation.

Renal calculi produce a class of symptoms quite similar to gall stone colic, but the pain and tenderness is confined to the kidney region and radiates over the course of the ureter to the groin. These conditions are neither one accompanied by fever or leukocytosis at the outset. The X-ray is of very little value in locating gall stones

but coupled with proper radiograms of the ureters and kidneys, is the most positive finding in renal calculi.

Interolyths, impactions and worms rarely produce symptoms except of intestinal irritation, and occasionally, obstruction. However, I have operated a case under the diagnosis of appendicitis and found the irritation in the appendix due to pin worms. Foreign bodies which are swallowed, or introduced through the rectum, produce symptoms in proportion to the damage they do, and are of interest most often as curiosities.

Sarcoma and carcinoma, do not produce acute symptoms, except those of obstruction, infection, or hemorrhage.

Cysts and fibromas may produce symptoms from infection, obstruction or hemorrhage, but most usually from a torsion of their own pedicles, which produces acute pain and vomiting without an early rise in temperature, or an increased leukocytosis. Most frequently they are easily palpated, and are perhaps more often diagnosed after the abdomen is opened, since all surgeons and laymen alike rarely delay operation when they can feel a tumor. This does not necessarily mean that the urgencies in these cases demand operation, but there is a tendency on the part of everybody to pluck the tumor. Hypernephroma and hydronephrosis present no difficulties in modern methods of diagnosis.

Cicatricial bands and adhesions concern us in the acute symptoms they produce by interference with the onward movement of the bowel contents, and will be discussed later under "Obstruction of the Bowel." Ectopic gestation can hardly be confused with any other condition except a twisted ovarian cyst, accompanied by normal pregnancy.

Misplacements and torsions produce symptoms in four different ways: first, reflex action; second, tension; third, pressure, and fourth, strangulation.

Hernias, volvulus and intussusception produce acute symptoms of obstruction. Obstruction of the bowel, for practical

purposes is best classified into mechanical and paralytic. Mechanical obstruction is of two kinds, obturation obstruction and strangulation obstruction, and is produced by hernia, volvulus, intussusception, cicatricial bands or adhesions, foreign bodies, and new growths. Paralytic obstruction is produced by infections or toxemias, interference with the nerve supply, which may be direct from injury of the cord or the afferent nerves; or reflex action, from diseases or injuries of the chest, neck, other abdominal organs, or extremities; and interference with the blood supply is produced by injury, thrombosis or emboli in the mesentery vessels.

The first symptom of a mechanical obstruction is pain, sudden in onset, severe and colicky in character.

The second symptom is vomiting, which is persistent, and gradually increases as the disease wears on. It is first mucus and watery fluid, which becomes more profuse and darker until it finally takes on what we have termed fecal vomiting. It is of the projectile type. Distension does not begin early, but is always present as the third symptom. It is sometimes possible to outline this distension above the obstructed bowel with flatness below. There may be a number of small bowel movements, especially in obturation obstruction, which will throw us off our guard unless this is kept constantly in mind, but usually there is no bowel movement after the bowel is emptied below the obstruction and very little gas is expelled.

In intussusceptions, there is frequently severe and bloody diarrhea. This also occurs in paralytic ileus, produced by embolus or thrombosis of the mesentery artery. A valuable point in differentiating these two conditions is that intussusceptions occur in children while obstruction of the mesentery artery occurs in adults, most frequently between the ages of 25 and 35. The temperature remains normal or subnormal until the disease has progressed to the stage of absorption of toxins from the obstructed bowel. Borborygmus is periodical and in time with

the colic pains, and produces a rather loud explosion or noise when it strikes the obstruction. It is very readily heard with the stethoscope and is a very valuable differentiating point between mechanical and paralytic obstruction.

We are frequently able to outline a mass by palpation. It is of importance to always remember that a physiological dose of morphine will completely mask the symptoms of an obstruction, for six or eight hours, and may delay the diagnosis until it is too late to give the patient surgical relief.

Paralytic ileus is more gradual in its onset and presents as its first symptom distension of the bowel, followed by vomiting which is of the gulping type. The vomiting progresses as the disease advances, until it is finally of the same character as the vomiting of mechanical obstruction, except the gulping type usually remains throughout the disease. The abdomen is generally and evenly distended. There is no mass that can be outlined, little if any tenderness, and there is a complete absence of pain until the distension has progressed far enough to produce traction upon the mesentery. There is usually complete inability on the part of the patient to obtain either bowel movement or passage of gas. These conditions, however, are often amendable to treatment and the patient's condition in place of rapidly progressing downward, suddenly takes on a new feature and is completely relieved by medical treatment. Dilatation of the stomach is a part of the same process as paralytic ileus and deserves no further discussion. Internal hemorrhage presents no unusual difficulties in diagnosis, and the relief obtained depends upon the causative factor and the condition of the patient.

Infarcts, so far as I know, are diagnosed by the pathologist and are rarely recognized before he acquires the specimen.

The symptoms that are produced by injury must necessarily be in keeping with the extent of the injury and the organs

involved, and cannot be discussed in the scope of this paper.

—B— GENERAL PSYCHIATRY FOR THE GENERAL PRACTITIONER

2. Mental Disease After Influenza

(The Effect of Influenza on the Human Mind)

KARL A. MENNINGER, M. D., Topeka

The effect of influenza on the human body in the production of the primary illness, and the various secondary manifestations such as the dreaded pneumonia, pleurisy, empyema, eye and ear maladies, etc., is quite familiar to millions of people all over the world today. A terrible familiarity was achieved as a result of the ravages of the epidemic of 1918-19. In the wake of the epidemic there were, all told, millions of deaths to say nothing of the prolonged complications of other sorts—such as those just mentioned.

In addition to these, however, one of the most disastrous results of influenza is one of which little is known or spoken either by the people or by the physicians, and neither in medical or in news publications. This is the havoc wrought upon the human brain by the poisons of influenza. For it has been known for hundreds of years that influenza was possessed of an exceptionally powerful brain poison. In the description of an epidemic in Germany in 1385 there are mentioned cases of mental disease wrought by it.¹ It is, moreover, familiar to innumerable sufferers from influenza in the recent epidemic that the illness is followed by a long period of nervous and mental disquietude, irritability, lassitude, or depression. A noted Scotch brain specialist (Claustron) of thirty years ago wrote it as his opinion that "the whole moral tone of Europe was lowered" by the epidemic of the years 1890-1892. It seems not unlikely that the great financial panic of 1893 was at least indirectly due to the depressing effect of the preceeding three years of influenza, and the mutual loss of

¹ Schnurrer, Chron. der Seuchen., t. I., par 352; 1385.

confidence and enthusiasm which it is well known to produce.

But, in addition to these mild nervous and mental effects, influenza deals much heavier blows to some of its victims. All manner of "nervous" diseases are observed subsequent to it. Spinal cord diseases of many sorts occur, and diseases of the peripheral nerves as well. In common language these are called, or rather miscalled, all sorts of names such as neuritis, palsies, shakes, etc. Far more varieties of trouble occur than any common names have been invented for.

But by far the most serious of all the nervous and mental sequellae of influenza are the severe cases of mental disease produced. These are what are popularly but erroneously called "insanities." First of all it should be remembered that there is no such disease or symptom as insanity. This word is a legal word, and not a medical word at all. It simply means that the judge of the probate court of the county in which the person lives finds such a person sick enough mentally to be cared for and detained by the state. The word is not used (correctly) by doctors, but by lawyers. It would be very fortunate if it were dropped from our language entirely.

But what is meant usually when the average man speaks (erroneously) of "insanity" is some form of mental disease, which may or may not be a case of insanity, according to the decision of the probate court. And it is of these mental diseases, of which there are many sorts and kinds, that we are speaking now. Influenza called forth many cases all over the world. No one not directly interested in such affairs would suppose how numerous these cases have been. As a matter of fact there is no definite knowledge as to just how numerous they have been, but approximate estimates are possible. These are as follows:

Grouping all forms of mental disease together there were nearly two hundred such cases in one mental hospital in Boston. This hospital is fed by a territory of between one and two million people. On

the basis of the fact that there are many private hospitals and one state hospital in the same district, we may quite fairly take the lower figure. On this basis, if two hundred cases are brought to one hospital from a population of 1,000,000, there are throughout the United States, with its population of 100,000,000, some twenty thousand cases taken to state hospitals. However, since the grippe was much worse in the East than elsewhere, we will discount this 50 per cent making 10,000 cases. It is estimated that probably less than one half of the cases of major mental disease ever get to state hospitals and hence there were perhaps some twenty thousand cases of influenzal mental disease in the past six months in this country.

This means that throughout the United States there were probably about as many cases of mental disease as there are inhabitants of Pittsburg or Salina. This frightful number should be modified somewhat for the reason that undoubtedly some of these cases would have developed with or without the added effects of influenza. Nevertheless there is no telling what proportion this would be, and there is also no doubt but that influenza was the direct cause of thousands and thousands of these cases.

On this same statistical basis there would seem to have been in Kansas, in the past six months, about 400 such cases. This does not include thousands of milder cases. In the Topeka Daily Capital last winter appeared an article from an authoritative source stating that influenza, having filled to running over all the general hospitals during the epidemic, was thereafter filling in the same way all the state hospitals. This was literally true, as all of the state hospitals received a marked increase in the number of admissions, many of the cases directly and avowedly the result of influenza. The number of such admissions at the Topeka State Hospital was much less than 100, according to an approximate estimate given by Superintendent L. M. Perry to the writer, but in addition to these, of

course, there are to be considered those admitted at Osawatomie, Winfield, Parsons, etc., and the cases treated in private hospitals and sanitariums, and finally those kept at home.

These figures while probably inaccurate are important for this reason. It is generally recognized and expected that the coming winter will see a second wave of the epidemic of influenza. Such has always been the history of influenza epidemics. And such being the case, it will undoubtedly be followed in turn by another wave of mental disease. Now if anything like the same incidence occurs, the number of mental cases will far exceed present facilities for their care and treatment.

So much for statistics, estimates, and prophecies. It is sufficient to say that the importance of influenza from the standpoint of mental disease is apt to be underestimated. Yet probably every medical practitioner in Kansas saw at least one case last winter, and will no doubt see more cases again this winter. The immediate question asked by the thinking physician is *what form of mental disease ("Insanity") is it that follows influenza?* and *What shall we do for these cases?*

To briefly answer the first question is the purpose of this paper. The article for next month proposes to answer the second, but it is important to remember that since *treatment* depends upon *diagnosis*, the latter comes first. Hence this preliminary paper on diagnosis.

It is essential that we keep in mind that mental diseases are of distinct types and names just as are physical diseases. We are eager to differentiate diseases of the body as heart disease, hepatic disease, vermiform disease, and just so diseases of the mind are to be differentiated and the treatment and prognosis made accordingly. It is a singular fact that the same man who will be meticulously painstaking in deciding whether a lesion is of the mitral or the aortic valve will ruthlessly class all mental syndromes together as "insanity" as if that were of any value to him or to the patient!

And yet one cannot infer that the mental diseases subsequent to influenza are deserving of the appellation "influenza psychoses" as if that were as distinctive as "typhoid spine" or "malaria spleen." For as matter of fact, *there is no influenza psychosis*. The importance of this fact will become more and more apparent. The Influenza is followed not by *a specific one form* of mental disease, but by *many forms* of mental diseases, and it is absolutely necessary to determine which sort, which form or type, one has to deal with. The medical practitioner would be aghast were it an acknowledged practice to treat pneumonia, empyema, pleurisy, otitis media, erysipelas, arthritis, tonsillitis, conjunctivitis and all the various other complications of influenza *precisely as if they were the same disease*, instead of treating each according to the principles of its peculiar pathology. Yet the analogy of treating *all* mental disorders following influenza as if they were of the same great family, when as a matter of fact they are of many sorts and species, does not impress some as analogous, which however it certainly is.

The first step in recognizing the effect of influenza on the human mind, then, is to recognize the fact demonstrated by detailed studies of the matter² that *all known forms* of mental disease may be evoked or emphasized by influenza. In a previous paper in this journal I presented the known forms of mental disease in a simple and easily grasped table, as prepared by E. E. Southard³ of Boston, and modified by myself. This list of twelve

² Jelliffe, S. E., Influenza and the Nervous System, Phil. Med. Journ., Dec. 27, 1902. Jelliffe, S. E. Psychoses with Influenza, N. Y. Med. J., 108, 725 Oct. 26, 1918. Menninger, Karl A., Psychoses Associated with Influenza I. Statistical Analysis, Journal A. M. A. 72:235, Jan. 25, 1919. Menninger, Karl A., Psychoses Associated with Influenza II. Expository Analysis, Archives Neurology and Psychiatry, II, p 291, Sept. 1919. Menninger, Karl A., Influenza and Neurosyphilis, Archives Internal Medicine, 24:98, July 1919. Burr; Mental Complications and Sequellae of Influenza, Med. Clin. of N. A., 2:709, Nov. 1918. Harris, Waterman and Folsom, and numerous others.

³ Journ. A. M. A., October 19, 1919, and numerous others.

families, each with its minor subdivisions which it is the psychiatrists duty to elaborate, is quite within the grasp and ken of every general practitioner, and it is one of the aims of our Mental Hygiene movement that every medical man know at least this much about psychiatry. To review this list, it will be recalled that the diagnostic difficulties increase with the descent of the list, and the groups should be eliminated progressively and in order, from the top down. These are:

BRAIN SYPHILIS (neurosyphilis is a better term.).

FEEBLE MINDEDNESSES (note plural number).

EPILEPSIES (principally in the idiopathic form).

DRUG DISEASES (alcohol, morphin, etc.)

GROSS BRAIN LESSIONS (brain tumors, apoplexy, etc.)

DELIRIUMS (with and without fever).

MENTAL DISEASES OF OLD AGE.

SCHIZOPHRENIA (formerly called dementia praecox).

PARANOID PSYCHOSES (a group introduced here by myself).

MANIA AND MELANCHOLIA (often associated and closely related).

PSYCHONEUROSSES (hysteria, neuroses, etc.)

VAGUE AND UNCLASSIFIED FORMS (including psychopathy).

How, then, are each of these groups affected (produced, modified, etc.) by influenza? Can influenza cure morphinism? Does hysteria appear during or as a result of influenza? These are some of the questions which we purpose to consider systematically, in the order of the twelve groups.

BRAIN SYPHILIS, or Neurosyphilis. It has not been unusual to see cases with a history something like this. Until November 1 John Jones, aged 45, had always been considered an unusually well man. True, he had complained once or twice last summer of a headache or of mild fatigue, but such trivial symptoms were quite justifiably ignored. In November he had influenza although not particularly severely. His

convalescence was uneventful, but shortly after he had regained his feet he was observed to be acting queerly. From this the story would go on in various ways, sometimes with sudden gross conduct disorder, sometimes with a continuation of minor eccentricities, sometimes with evidence of severe mental incompetence. These cases would come to the hospital and upon close examination neurological, psychiatric, and serological (blood and spinal fluid) would prove to be frank cases of brain syphilis (general paresis, et al.)

Another common observation was that of cases who for some months or even longer had been showing mild symptoms of something wrong, a something to which no one had applied a name, and in fact which often had caused no considerable concern. After influenza these symptoms would bloom out strongly and the unfortunate victim would present the picture of general paresis of a severe grade, with marked mental deterioration ("dementia"), etc.

Influenza may then precipitate full-fledged brain syphilis in previously (apparently) well persons, and augment it tremendously in those previously showing only slight signs.

FEEBLE MINDEDNESS. Influenza, unlike meningitis, scarlet fever, etc., is not likely to produce total loss of intellect, resulting in idiocy. If it does so at all, it is extremely rarely. On the other hand it does have a powerful effect on the brains of children already lacking in intellectual power. A number of interesting cases have been reported in which children rating perhaps as imbeciles, would be reduced by influenza to a mental ranking of idiots, or a corresponding reduction from "moronity" (high grade feeble-mindedness) to imbecility (middle grade feeble mindedness), and other cases in which imbeciles have developed psychosis.

EPILEPSY. Influenza has been accused by various writers (following the epidemics of 1890, etc.) of producing or exciting epilepsy. Possibly such is the case, although I have never seen an instance of it

nor have any been reported for the past twenty-five years. It is more likely that influenza calls forth epileptic attacks in persons already possessing the epileptic tendency, which is virtually to say that they always had epilepsy. It is a truth well known to psychiatrists, although sounding somewhat paradoxical, that many epileptics never have convulsions. Influenza may precipitate them in some, however, and I have observed cases where influenza has entirely changed the nature of the attacks. In other cases it has increased the frequency of the attacks, in still others it has decreased them. We know so little about epilepsy, and so little about influenza that it behooves us not to draw any dogmatic conclusions about their interrelations.

DRUG DISEASES. This group deserves scant mention, now that alcohol is gone, and morphin going. There is this to say, however, influenza combines with any of the drugs that cause delirium and produces a chronic delirium which sometimes baffles attempts at solution.

GROSS BRAIN DISEASE. About one hundred years ago it was observed that influenza was sometimes followed even in young persons by apoplexy, a brain vascular lesion which is of course seen usually in middle aged or older adults. This was studied and found to be due to a brain hemorrhage or rather brain hemorrhages, as in addition to one large lesion producing clot there are usually many small bloody specks, like flea-bites, as Leichtenstern has suggested. Influenza has apparently corroded the blood vessel substance so that multiple diffuse hemorrhages occur, some of which are large enough to produce symptoms of apoplexy. Whether or not the recently discussed "sleeping sickness" or epidemic encephalitis lethargica is similar in causation is yet in dispute.

A few other forms of gross brain disease follow influenza, but this is by all means the most frequent and it is rare enough.

I have presented one case in detail in a recent article.⁴

DELIRIUM. Delirium is the name that has been for hundreds of years applied to the transient mental disturbances accompanying bodily illness, particularly fevers. It has been extended, perhaps not correctly so, to mental disturbances of somewhat similar symptoms which follow the fevers, and gradually enlarged to include almost all mental diseases associated with obvious physical disease providing they get well in a reasonably short time.

Of course this is not very scientific, and there have been strenuous efforts on the part of some of the students of research in mental disease of late years to determine what delirium is, or at least upon just why it should be called delirium. For our purposes we may say that delirium is a familiar altho inaccurate and ill-defined word which means recoverable mental disease secondary to obvious physical disease.

All sorts of deliria accompanied the influenzal attacks in the recent epidemic. Some writers have stated that delirium was rarely seen. That is not true. It was not the rule, by any means, but it was very common, and I have personally seen many cases. One variety is the simple "mind wandering" which has been the theme of melodramatic stories, poems, etc. ("The Engineer's Last Ride," etc.) for decades. This is characterized by partial loss of consciousness, and the existence of a dreamy bewilderment, with fleeting visions and voices. It comes at all stages of the disease, before, early, late, and after. Another variety is simply a more severe form of the same thing, in which the patient's consciousness of his environment is more nearly entirely lost, and in which he is more vividly surrounded by an imaginary world, often terrifying and disturbing. In these cases the danger to avoid is a violent reaction of the patient to his hallucinations. He may spring from

⁴ Menninger, Karl A., Psychosis Associated with Influenza. Archives of Neurology and Psychiatry v. II, pp 291-337, Sept. 1919.

his bed believing himself about to be murdered by beasts, and despite all ordinary precautions spring from the window or rush into the street. Sad accidents have thus occurred.

Another form of delirium is one frequently seen after the influenza is supposed to have subsided.

"Muttering delirium", "coma", and various others of the types seen in profound illness have been observed with influenza. They are usually seen only when the physical state of the patient is by all means the most urgent need of treatment, and hence do not merit discussion here.

Two forms of delirium seen after influenza, rather than during the attack, were peculiar and quite important. One was a form in which the patient wandered away during his convalescence, and either came to himself or was picked up at some distance from his home unaware of his whereabouts or the means of his getting there. I have suggested the name of "delirium errant" for this. Another type which I have called delirium schizophrenoides is one in which the diagnosis is very difficult. It strikes the examiner at first as a case of excited "dementia praecox" and the longer the case lasts, the more it looks like this, but suddenly it begins to recover and soon gets entirely, or almost entirely well.

The MENTAL DISEASES OF OLD AGE which constitute the next group are of course not frequently seen precipitated by influenza, chiefly, however, because of the comparative rarity with which influenza attacks the older people. Occasionally, however, cases of "senile dementia" and other forms of mental disease seen in elderly people appeared immediately or shortly after attacks of influenza.

The eighth group is the one of SCHIZOPHRENIA or dementia praecox, the disease of mental queerness. There is a long, sad story to tell in connection with this disease. It is one of which we do not know the cause or cure, and yet patients afflicted with it constitute approx-

imately half of all the state hospital inmates in the United States, and in fact in the world! Now the curious thing is that it is by all means the most frequent mental disease group following influenza. This strange fact is not yet fully understood, but when it is considered that more cases of this form of mental disease followed influenza than all other forms put together in the recent series we studied in Boston, it will be seen that there would appear to be something more than an accidental or incidental relationship. It is possible, altho of this we are by no means convinced, that this disease is in some cases at least the indirect result of infectious disease, that is to say that it is the effect on the brain (mind) of some by-product of the action of some infection, of which certainly influenza would seem to be one. If this proves to be true, a great discovery in the science of mental disease will have been made, since it will probably point the way to an approach to successful curative treatment of this terrible disease. PARANOID PSYCHOSES may for the present be considered as part of this group.

The "circular folly", as it was once called, or the mania-melancholia group comes next. Some may wonder why these are thus grouped together, and I would explain that it is well recognized that true mania and true melancholia represent two different extremes of the perversion of the same faculty, the emotions or affections. Patients subject to one are likely to suffer from the other, as well, sooner or later, altho this does not always occur by any means. Now instances of the occurrence of mild depression after influenza are very common, and are known to practically every layman as well as physician. But true melancholia, or the psychiatric entity known as depression was found not to be so common as might be supposed. Nor were the excited states known as true mania very common. Both did occur, both in initial and repeated attacks, but they were rather unusual, nevertheless.

PSYCHONEUROSES are the diseases masquerading under such names as neurasthenia, hypochondriasis, hysteria, neuroses, shellshock, etc. They have been known to follow influenza for hundreds of years, and they may occur then for the first time in the patient's life. They were seen in great numbers after the recent epidemic, and in fact probably almost every practitioner in the country is treating or has knowledge of at least one such. They are extremely difficult to treat successfully, as will be dealt with in the next article, but fortunately the ultimate outlook is usually good. The commonest form is one of hypochondriasis, in which the patient is almost one big bundle of laments, complaints and rebukes. I had one such—a usually quite intelligent man, a teacher, bitterly denounced me for attempting to take a specimen of blood for a Wassermann test, saying that he would “surely bleed to death thru that needle and you will never be able to stop it.”

The last group of all is a sort of a rag-bag for the odds and ends and miscellanies that cannot be classified elsewhere. One form which some would place here is the sex-pervert and others with what was once called “moral insanity”. These cases are so little understood that it is useless to discuss them statistically. I saw a few cases which seemed to have been precipitated by influenza, or at least led on to rather worse manifestations than usual. But on the whole we may simply say that this remains an odd and unsettled group, both inherently and in regard to the matter at present under consideration.

SUMMARY

To sum up this article then we find that influenza is a potent poison to the brain and to the nervous system in general. It evokes in some way mental diseases of every known variety, including representatives from all of the twelve major groups of the Southard classification. How it does this—whether by producing the mental disease directly as it sometimes seems to do, or by precipitating a latent psychosis as seems to be the case at other

times, is not certain. Possibly it does both. At any rate brain syphilis, epilepsy, feeble-mindedness, coarse brain disease, drug disease, deliriums, senile mental diseases, schizophrenia, paranoid psychoses, mania and melancholia, psychoneuroses and representatives of a miscellaneous group have been observed in sequence to the grippe. Hence the effect of influenza on the brain cannot be thought of as a specific, and the result is apt to be any one of many forms of mental disease, but this propensity for the production of some mental trouble, mild or severe, transient or permanent, one sort or another, is one of the most striking characteristics of the terrible disease of which we have recently seen, unfortunately, too much.

—————B—————

Fables for the Kansas Doctor

By RENNIG ADE

Once upon a time there was a Kansas Doctor practicing in a small town, making a living for himself and family and fairly contented. His age was 45, his weight 195 pounds, his habits good, and no life insurance company had ever turned him down after his note had been liberally discounted by his banker.

He played ball once a year at the Woodman Picnic when the Fats played the Leans. This was all the exercise he took except mowing half his yard every spring. A crippled colored man attended to it the rest of the season, and in return got a few bottles of the tonic from the five-gallon lactated pepsin jug and a regular supply of the “liver pills” known as Hinkle’s which since the war have advanced over 9 cents per thousand.

At the outbreak of the Great War the Doctor like others of the profession joined the Medical Reserve Corps and immediately left for the city to buy a new uniform. The conscienceless, prepuceness profiteer, Cohen by name, who trafficked in war regalia, stung him three hundred dollars for a seventy-five-dollar outfit, but as it brought into relief the massive calves, and sort of held in abeyance the

42-inch waist line, the bargain was made and the home bank did the rest.

In time the call came, the farewell reception was held in the basement of the Methodist church where refreshments were served by the ladies and two violin solos were rendered by the daughter of the President of the Board of Trustees who had been taking lessons for almost a year and could play two or three pieces clear through. After some delay the wife and family were duly assembled, and all left for Ft. Riley.

The Doctor felt rather lonesome at first, as he was the only physician among 650 surgeons, but later in the day he became a surgeon also.

The officers' family quarters were not as he had been led to believe, and he was compelled to send the wife and four children back to her folks, who were tickled almost to death. Feeding ten-year-old boys 50-cent eggs and 65-cent bacon is one of the most laughable things in the world. Grandpa's pension almost kept them in butter.

The first three months of the Doctor's training were spent in running up hills, jumping hurdles, setting up, setting down, walking lame, and rolling over.

This was under the direct supervision of Major Pimple. The major swore beautifully and could smoke two packages of Camels in a day. He had no other qualifications.

After three months of this intensive training the Doctor was asked if he had a preference for any particular kind of work. Being pretty well fed up on the strenuous life, naturally of an inactive physical temperament, and not wishing to butt in ahead of more ambitious men, he expressed a preference for housemaid's knee and femoral hernias.

After considerable correspondence with the Housemaid's Knee Department at Washington, his request was turned down and he was sent to Camp Mills, N. Y., via Seattle, to administer typhoid vaccine to a bunch of three Indians who were expected in from New Mexico. Three weeks

later he was ordered to Oglethorpe by the way of Camp Dodge. By steady traveling at 7 cents per, and getting help in fixing up his traveling vouchers, he managed to get enough ahead to pay his taxes and Woodman insurance, besides sending a little home to the family. His last long trip that paid pretty well was to Camp Cody, New Mexico, where he was sent to inspect a recently constructed latrine.

During all these trips he was not once embraced and kissed by a beautiful patriotic young lady of 19, as he had supposed would be one of the common horrors of war.

Word from home informed him of the locating of two new doctors in his town, and business good on account of the "flu."

Several months after the armistice was signed he was discharged from service, and went back to the old town to start in anew.

He hurriedly donned his civilian togs and packed the army clothes away in the lowest part of an obscure corner of the attic, and he was much pleased a few days later to see one of his colleagues who had been notoriously loyal in keeping the home fires burning, walking round attired in army shirt, puttees, etc., that had been taken in on a doctor bill from an indignant returned soldier.

A number of his friends asked if he had been out of town, as they had tried to get him on one or two occasions and central had said "the phone was out of order."

He reassembled his family, collected \$3.75 fees turned over from brother practitioners, fished the cat out of the cistern where it had been for two months, made a first payment on a jitney, and gradually got back into the game again, mentally vowing that that man Sherman was a level-headed old boy.

Moral: There aint any.

—————R—————

"Adverse personal criticism borne well is a sign of strength of character."

R

Bad manners in practice is evidence of degeneration.

Comments and Excerpts—By The Prodigal

Team Work and the Polytechnic Medical Work Shop.

The late Dr. Williams of Cincinnati was a pioneer eye specialist of America. He is credited with the remark, "A Doctor has to destroy a bushel of eyes to become an oculist." The principle applied to the internist also in those days. There was more truth than fiction in the saying. The fiction only remains so far as opportunity is concerned. Hospitals and team work have changed educational methods and results. The community hospital is the polytechnic workshop of the medical man and the mecca of the medical student and nurse.

The auto and air craft annihilate space. With good earth roads and skyline boulevards unobstructed, a hospital a score of miles distant is on the doctors front lawn. Art and science have perfected the means and the way to get there. The signs of the times are coquetting the doctor on in numerous, better and more successful methods of serving and helping the sick man. The doctor with the pep accepts the challenge and governs himself accordingly. There is no question as to the good resulting to the community, the medical student, the nurse, the doctor and the profession at large, in team work and in a community hospital. To the community it is a God-send to have a place near home where the continued fever cases can be sent and cared for properly; where all surgical cases can be treated scientifically; where the prospective mother can go for the accouchment a week before the expected confinement and get a few days rest before the ordeal of childbirth. The relief to the family from the care, labor, anxiety, and the uncertainty of carrying out the doctor's instructions and the liability to mistakes, each and all favor the community hospital. Aside from this, serious sickness in the home unfits the well members of the family for home duties and remunerative work. It is the medical student's haven to begin his life work near home with qualified

teachers and working and familiarizing himself with the material and eccentricities of that elusive something called human life. Such an opportunity goes far toward easing up on his finance. The time it takes and the requirements to be fulfilled and the exactions imposed on the future graduate in medicine call for a big bank account, a long life, or the community hospital to grow up in.

An interne hospital experience being an essential requirement to graduate in medicine and there being not enough places to go around, there would be too many applicants on the waiting list without the community hospital. And by the time a young man would get through the medical college on the intership requirement, he would be too old to practice medicine. He would be so well educated that the whole brain substance would be a lump of gray matter. The community hospital is one way out to get the knowledge and be able to practice a few years after graduating.

It is the ideal place to school and fill the demand for nurses. The community hospital makes better mothers, in the sense of knowing how to care for those to be. To the half dozen or more community doctors doing the team work, the benefit to them professionally is invaluable. It is the nucleus or educational center from which radiates professional medical activity, strengthening all who come under its influence. It is a cure for that ennui or lack of interest in scientific medicine so often seen in the general internist a few years after graduation. Such an enterprise encourages friendship and is a panacea for petty jealousies by occupying the time and mind in self improvement and preparation for the work, the growth and success of the hospital.

The practice of medicine is a man's job. Team work enables the physician to do the work easier and better. Team work is the newer or readjusting method of practice.

Team work afforded by a community hospital relieves the congested medical centers and diffuses an intelligent rivalry

and betterment of the esprit de corps in the rural medical profession as a whole. It develops physicians and surgeons and prepares them to meet a world crisis without loss of time or months of training, in such an event.. The community hospital lessens the physical labor and exposure of the physician. It places no greater obligation on the individual doctor, but it divides his responsibility. It affords more practical help in cases of emergency. It keeps the doctor in a more plastic condition mentally to be moulded into the newer ways and trend of thought in methods of diagnosis, treatment and discoveries in disease. The doctor is enabled to live more like a human being than an owl. Such an allignment in hospital work lessens the doctor's night rides to a minimum and lets him sleep and keep himself in a condition to study and be better prepared for his work.

He is not troubled with insomnia listening for the door-bell or phone calling him in the wee small hours to see the typhoid patient he visited during the day. The interne allays the midnight fear of the sick one and there are no neurotic friends present to increase the fear of the afflicted one. It means a more strenuous mental life for the doctor. He has to get a double cinch on his works and has no time for self pity or jealousy of his neighbor.

Where there is a lack of hospital facilities, in a well settled community, at a center of a ten mile radius, one can be supported by a little education of the laity. The hospital should be begun on a small scale. A sightly location should be selected for the building, if none, then cleanliness, neatness, and system should be scrupulously carried out. And the Shibboleth should be "Watch Us Grow."

The business end comes first. This should be in the hands of one A. I. business man, a common sense attorney at law and an all round doctor. The staff of physicians should be advisory only. Canvas the community. Each doctor has his own patrons. Then call a public meeting in the different neighborhoods. The business

man and attorney can do the most of the talking. Tell the people what is proposed to be done. Take them into consideration. Study the subject from every standpoint. The convenience to the people, the economy, doing away with the dread of the afflicted one of going away from home and friends, of being among strangers and probably placed in a ward full of sick and distressed patients. Compare this condition with the home hospital, home doctor, with home nurses, with natural and fresh food to eat, a clean room, with pleasant surroundings and away from the noise and din of a big city or hospital. Where the longing to see home folks and friends can be gratified and the soothing voice and friendly face of the family doctor can be heard and seen daily and a staff of home physicians at their service on call. Such a condition and surroundings soothe the nerves and puts the mind of the sick one at ease. By way of digression we'll say that mental therapeutics is in the saddle. "A sick body is not infrequently the expression of a sick mind. In many instances, the removal of an outside influence has an important scientific value as a measure of treatment and has as pronounced physiologic action as the most potent pharmacopeial drug." Again, "Reassurance is often as comforting as opium and has fewer after effects."

If perchance the doctor is so situated that a hospital is near, he should become so useful to the management that he is missed on roll call. He may not leave as much money to spoil his children by living up to the best there is in him professionally, but it is by doing a little more for humanity than humanity does for us that makes the world better and happier and makes our own lives worth while and an excuse for, why we live.

The community hospital will not interfere with any other hospital that is worth while. There are enough sick people to support a local hospital and the population is increasing daily. Not only that, but it is due the community and it is becoming fashionable. It is a sensible fash-

ion. It is an economical, practical and humanitarian one.

The old order of teaching and practicing medicine and caring for the sick is being revolutionized—readjusted. The bad things in it are being eliminated. The good things continued and the newer and better things are being grafted on to the teaching, practice, care and treatment of the sick. In other words the dawn of reason is breaking in medicine.

MR. EDITOR: You called the attention of the medical profession of Kansas to "Our Library," the Stormont Medical Library, in the last number of this journal and gave a suggestion, "how to get it before the medical men that it might be used more." Since the journal reaches the majority of the doctors of the state, one way to acquaint the profession with the contents of this library would be to get the catalogue of the library and publish a section or more of it each month. The title of the books first and then the periodical until the whole catalogue is published. Or put out an enlarged number of the Journal with the title of the books and the next number containing the title of the periodicals. It would get it to the profession quicker and with less cost to the society.

A private library is an index of a man's financial or intellectual ability. The use he makes of it is the measuring stick by which he is gauged in the profession. A large percentage of the medical literature put out is more verbiage. And there is such a great amount of it that it is bewildering. As you suggest Mr. Editor, "it requires someone who is competent and painstaking and sufficiently interested to do the work." He should be financially disinterested in any particular publication.

After this competent man has made a selection of books or periodicals, his selection should be reviewed by three competent practitioners to make sure, doubly sure, in perfecting the menu. The profession of Kansas is favored by such a library;

but like all gifts, it appears to be valued at the cost to us.

Continue your propaganda. You are headed the right way and while we older ones cannot be moulded anew the younger men may be made to see our sin of omission and govern themselves accordingly.

Your comment on "Prevention of the Recurrence of Epidemic Influenza" is timely. The method of prevention in some sections of our country is questionable, compelling the people who were well to wear masks. Fresh air is essential to maintain health. The power of resistance to disease depends upon the vital energy, else everybody would be sick or dead. Rebreathing ones own breath is as poisonous and deleterious to health as to breath anothers breath. Re-breathing stale breath, which has been held in the meshes of the gauze until the effete matter in it has time to rot, will make a well man sick; or breathing fresh air is a myth and there is no such thing as self poisoning from foul air. If the sick or suspected sick ones must mingle with the crowd mask them while they mingle. Make masking compulsory with them. It is a mistake to muzzle and scare everybody and depress them until they sicken. Give the well ones a chance to keep well by breathing fresh air.

—R—

While not generally known it is a fact that during the nineteen months of our participation in the war with Germany the casualties from accidents in peaceful America were more than twice as great as the casualties among the American troops in France. The statistics of the United States Census show that more than 70,000 persons died each year as the result of accidents in America. It is estimated that 20,000 of these deaths are caused by industrial accidents and 50,000 by accidents in the streets and homes.

—R—

A little girl in Clay Center told her playmate that Dr. Morgan brought them a new baby. "Oh," said the playmate, "We take from him too."

THE JOURNAL

of The

Kansas Medical Society

W. E. McVEY, M.D. - - Editor

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Clinical Evidence

We are coming to appreciate the unreliability of clinical evidence, at least, in so far as it is applied to establish the therapeutic efficiency of remedial measures. We do not accept with unrestricted confidence the results of experimental therapeutics, particularly the experimental therapeutics conducted in the laboratory upon various kinds of animals.

The profession has long since learned to look with suspicion upon such clinical reports as would at one time have occasioned a largely increased demand for some new compound or proprietary preparation. We would perhaps question the mental equilibrium of one who should proclaim that fifty years of clinical experience had convinced him that an infinitesimal dose of sodium sulphate repeated every two or three hours would cure cases of asthma of many years duration.

Before we had been told a little about the nature and causes of anaphylaxis, and before it had been suggested that certain cases of asthma were probably of that nature, a suggestion that regularly administered small doses of egg albumen would cure some of them, would have met

with equal ridicule—just as would the suggestion that hay-fever might be cured by the injection of pollen extracts.

No laboratory experiment would be likely to show any physiologic effect upon animals from such an infinitesimal amount of sodium sulphate as that mentioned, nor from very small amounts of egg albumen. Nor would such minute doses of sodium sulphate, or of egg albumen, produce any perceptible physiologic effect upon a normal man.

We must recognize the fact that there are substances which produce no discernible effect upon men or animals in their normal states, but which in certain pathologic states do produce very pronounced effects. Otherwise we could not explain many of our most popular methods of treatment. Many of these are based upon theories which were evolved from the laboratory and confirmed by clinical evidence.

Some of our long established therapeutic remedies were established upon clinical evidence and their action explained upon plausible theories. Some of these theories were later proven by laboratory tests, some of them were found unreliable and a true explanation of the drug ultimately found.

From the studies of recent years have been evolved some very different conceptions of the nature and causes of certain types of disease, and some very plausible theories of treatment. These theories are mostly, however, dependent upon ultimate confirmation by clinical evidence. Up to this time the clinical evidence presented has been in too many instances, either too meager, too indefinite or too unreliable to be safely accepted.

One should not be accused of undue pessimism, who fails to find, in the reports that have so far appeared, sufficient clinical evidence of the therapeutic efficiency of the treatment of asthma, even though its relation to anaphylaxis has been satisfactorily shown. Clinical reports on hay-fever for the present season are not yet available, but from observation one is not inclined to be enthusiastic over the re-

sults of treatment. Now that the nature and causes of these conditions or diseases have been established it is to be expected that some efficient plane of treatment will ultimately be perfected. Whatever these may be their efficiency must ultimately be confirmed by clinical evidence.

Clinical reports become evidence only when they go to establish a definite relation of cause and effect.

Perhaps the most prolific field for unreliable clinical evidence is in the treatment of pneumonia. The large list of remedies which have at some time been reported as near specifics in the treatment of this disease is sufficient proof of that statement. It was always later demonstrated that these very optimistic clinical reports were valueless as clinical evidence.

Dr. Bone reports that he has treated a hundred cases of pneumonia with quinine, or digitalis, or veratrum, or creosote, or serologic therapy, and that the mortality was nil, he has presented no clinical evidence of the therapeutic efficiency of the remedy he has used.

A few years ago one might have thought that nowhere but in the treatment of pneumonia could clinical reports be so readily come by, and definite data of real clinical importance be obtained with such difficulty. At the present time one might say this of influenza. Although conditions seemed most favorable for the accumulation of valuable clinical data, the reports were so conflicting and opinions so diverse that the profession is still unprepared for a possible recurrence of the epidemic. Even in the matter of prophylaxis, although opportunities for comparative tests could hardly have been more satisfactory, those most competent to observe and most competent to draw conclusions do not agree. Rosenow and Sturdevant conclude from their observations in prophylactic inoculation that "It appears from all of the facts at hand that by the use of a properly prepared vaccine it is possible to rob influenza of some of its terrors." McCoy concludes from his observations of the use of prophylactic vaccine against influenza,

in the Public Health Service, that "The general impression gained from uncontrolled use of vaccines is that they are of value in the prevention of influenza; but, in every case in which vaccines have been tried under perfectly controlled conditions, they have failed to influence in a definite manner either the morbidity or the mortality." Clinical reports were abundant but they failed to show that definite and constant relation of cause and effect required to evidence the prophylactic value of vaccine in influenza.

From a few facts we elaborate some ponderous theories and search the universe for additional facts to establish these theories, but in the search overlook the truth. We are too tenacious of our theories, perhaps, even in our clinical investigations. We see those evidences which go to prove our theories of medication, with a much keener vision than those which disprove them.

—————R—————

Who's to Blame?

One of the very important services rendered by the State School of Medicine to the people and the medical profession has been discontinued, at least temporarily, on account of lack of funds. While the government appropriated funds for the campaign against venereal disease those funds were available only to the extent of similar appropriations made by the state. Since the legislature failed to make any appropriation for this purpose the funds appropriated by the government are not available. Since the budget for the medical school did not include the maintenance of a laboratory for free examinations for syphilis and gonorrhea this work had to be discontinued. We have recently been informed that a sufficient fund had been appropriated by the Board of Administration and that the laboratory would be in operation again by October 1st.

Last year the cost of this laboratory was \$7,000, but this year the demand for its service has greatly increased. We are informed by the Dean that during the month of August there were made 740

free Wassermann tests and 1,080 free examinations of smears from gonorrheal suspects. If the Wassermann tests are counted at \$5.00 each, the minimum laboratory price, and the examinations of smears at \$2.50 each, it means that the people of Kansas were saved \$6,400 in one month by this one department of the medical school.

It is needless to say that the discontinuance of these free examinations by the state will most seriously handicap the work which has fairly begun in the control of venereal diseases. Naturally the last legislature is held responsible for this on account of its failure to appropriate the necessary funds. We must all share this responsibility, however, for we were rather indifferent in the matter ourselves. Those who attempted to secure the needed appropriation were apparently incapable of presenting essential facts and convincing data. It is a rare body of men that would have the temerity to ignore matters of such vital interest to the public as this, if properly made known to them. The members of the legislature are men of a fair degree of intelligence, and an ordinary amount of integrity, and at any rate, they hold the confidence of their friends and neighbors. They do sometimes submerge their personal and political interests in the larger problems of the public welfare. We do not believe that these men would betray the confidence of their constituents by refusing to provide the funds for so important a public work as this, if they were convinced that the purpose for which such funds were to be expended were legitimate and properly designed to promote the campaign against venereal diseases.

—R—

Enforcement of the Harrison Law

It was apparently intended, when the Harrison law was passed, that much in the medical use of narcotics should be left to the discretion of physicians. But, because there are in our profession as in all others those of too easy conscience and too greedy purse, this discretion is constantly being restricted. One of the recent Treas-

ury Decisions includes the following paragraph:

"The act of December 17, 1914, as amended by the act of February 24, 1919, permits the furnishing of narcotic drugs by means of prescriptions issued by a practitioner for legitimate medical uses, but the Supreme Court has held that an order for morphine issued to an habitual user thereof, not in the course of professional treatment in an attempted cure of the habit, but for the purpose of providing the user with morphine sufficient to keep him comfortable by maintaining his customary use, is not a prescription within the meaning and intent of the act. (*U. S. v. Doremus*, No. 367, October term, 1918, T. D. 2809.)"

This decision leaves very little to the discretion of the physician in the management of addicts, at least. There is some reason to believe, however, that a physician's judgment will be respected to such extent as his reputation for ability and conscientiousness will justify. One should bear in mind that in using his discretion he also assumes the responsibility and should be prepared to defend his action and his judgment should occasion require.

From a pamphlet of instructions sent to collectors of internal revenue by Commissioner Roper we quote the following recommendations which will give some idea of the latitude of discretion permitted a physician:

"In the administration of this important law many emergency cases will doubtless be presented to you calling for immediate and practical solution. You will be called upon by practitioners and druggists, and importuned by addicts to answer their questions. It is obvious that no inflexible rule can be announced covering all specific cases which may arise.

"Extraordinary cases which can not be decided by the collector should be at once submitted to the Bureau with a full and accurate statement of material facts involved. In view of the emergency already precipitated in certain districts the following suggestions, which are subject to modifications through further interpretation of the law by the courts, are submitted:

"With reference to persons suffering from a *proven incurable disease, such as*

cancer, advanced tuberculosis, and other diseases well recognized as coming within this class, the reputable physician directly in charge of bona fide patients suffering from such disease may, in the course of his professional practice, and strictly for legitimate medical purposes, prescribe narcotic drugs for the immediate needs of such patients, provided said patients are personally attended by the physician and that he regulates the dosage himself. The prescriptions in such cases should bear the indorsement of the attending physician to the effect that the drug is to be dispensed to his patient in the treatment of an incurable disease.

"Such bona fide cases of incurable disease should not occasion difficulty in the proper administration of the law, and the fact that the patient suffering from such incurable disease is addicted to the use of narcotic drugs should not complicate the matter. In this class of cases, as well as in others hereinafter mentioned, caution should be exercised to avoid being imposed upon by unscrupulous persons, and too much credence should not be given to the unsupported statements of the addict himself, because the confirmed addict will go far beyond the truth in an attempt to secure an ample supply of narcotic drugs with which to satisfy his cravings.

"The primary responsibility obviously rests upon the physician in charge of the case. The Bureau manifestly is not charged with the duty of laying down any fixed rule as to the furnishing of drugs or the frequency of the prescriptions in any particular case involving an incurable disease. The danger of supplying persons suffering from incurable diseases with a supply of narcotics must be borne in mind, because such patients may use the narcotics wrongfully, either by taking excessive quantities or by disposing of a portion of the drugs in their possession to other addicts or persons not lawfully entitled thereto.

"While the primary responsibility rests upon the physician in charge, a corresponding liability also rests upon the druggist who knowingly fills an improper prescription or order whereby an addict is supplied with narcotics merely for the purpose of satisfying his addiction.

"Cases will come to your attention where aged and infirm addicts suffering from *senility*, or the *infirmities attendant upon old age*, and who are confirmed addicts of years standing, will, in the opinion of a reputable physician in charge, require a

minimum amount of narcotics in order to sustain life. In such cases prescriptions to meet the absolute needs of the patient may be written and filled without involving a criminal intent to violate the law. Even in these cases every reasonable precaution should be exercised to prevent the aged and infirm addict becoming the innocent means whereby unauthorized persons may engage in the illicit use and traffic in these habit-forming drugs. Prescriptions in this class of cases should bear the indorsement of a reputable physician to the effect that the patient is aged and infirm, giving age, and certifying that the drug is necessary to sustain life.

"One of the principal difficulties in administering this law will arise in the case of the ordinary addict who is neither aged or infirm nor suffering from an incurable disease. *Mere addiction alone is not recognized as an incurable disease.* It is well established that the ordinary case of addiction yields to proper treatment, and that addicts can be taken off the drug and when otherwise physically restored and strengthened in will power will remain permanently cured. The average addict does not believe this, and it is symptomatic with him to have a fear and distrust of any treatment or cure. Wherever the occasion presents itself, the hope of successful treatment should be instilled in the minds of the unfortunates addicted to this terrible habit.

"The law as construed by the Supreme Court holds it to be a crime for any person, including practitioners, to furnish an addict with narcotics for the mere purpose of satisfying his cravings for the drug. The enforcement of this law as thus construed presents a problem attended with serious difficulties.

"Care should be exercised by investigating and field officers of this Bureau not to interfere with or harass the reputable physician, who, in the course of his professional practice and for legitimate medical purposes only, is in good faith treating a bona fide patient for the cure of addiction, nor the official representative of the local authorities who is administering narcotics to addicts in a proper manner to meet their immediate needs to prevent collapse. At the same time it must be understood that the so-called reductive ambulatory treatment does not meet with the approbation of the Bureau for the obvious reason that where narcotics are furnished to an addict who controls the dosage himself he will not be benefited or cured, and

in many cases he may, by deceiving or importuning a number of doctors, secure a supply for peddling purposes."

—————R—————

American Made Synthetic Drugs

P. N. Leech, W. Rabak and A. H. Clark report on the work which was done in the A. N. A. Chemical Laboratory in the efforts to overcome the shortage of synthetic drugs during the recent war. In particular they report on the examination of and the establishment of standards for procaine (novocaine), barbital (veronal), phenetidyl-acetphenetidin (holocaine) and cinchophen, or phenylcinchoninic acid (atophan), manufactured under Federal Trade Commission licenses. They report that the shortage of German synthetics was not felt seriously in most cases because the demand for them had been artificially created, and that the few which were in great need are being rapidly replaced by American made drugs. The report explains how the Federal Trade Commission granted licenses to American firms for the manufacture of German synthetics which were protected by U. S. patents, and how these licenses were issued only after an examination of the firm's product in the Association's Chemical Laboratory had demonstrated that its quality was satisfactory and equal to that of the drug formerly imported from Germany. It is interesting to observe, the report declares, that of all the synthetic drugs imported into this country from Germany and on which American patents had been issued, the demand was sufficient only to make it commercially profitable to manufacture four of them on a commercial scale, namely, arsphenamine (and neoarsphenamine), barbital (and barbital sodium), cinchophen and procaine. The chemists caution that, in view of the agitation to found an institute for co-operative research as an aid to the American drug industry, it will be well for the American medical profession to be on its guard against new and enthusiastic propaganda on the part of those engaged in the laudable enterprise of promoting American

Chemical industry (Jour. A. M. A., Sept. 6, 1919, p. 754).

Benzyl Benzoate

Although the benzyl esters have been known only a short time in medicine, the possibilities of their usefulness in certain fields of practice is becoming apparent. Benzyl benzoate has already been accepted for New and Nonofficial Remedies. The therapeutic applicability of benzyl esters arose from the investigation of opium alkaloids by D. I. Macht. The study demonstrated that opium alkaloids may be divided into two classes: the pyridin-phenanthrene group, of which morphine is the type, and the benzyl-isoquinolin group, to which papaverin belongs. The former was found to stimulate contractions of unstriated muscles, whereas the papaverin-like alkaloids inhibit the contractions and lower the muscle tone. A search for simpler, non-narcotic compounds of the latter which might still act in inhibitory manner on smooth musculature led to the use of benzyl acetate and benzyl benzoate. Ureteral colic and excessive intestinal peristalsis have been found to yield to the tonus lowering action of these two drugs. Apparently satisfactory results from the use of benzyl benzoate in dysmenorrhea have recently been reported (Jour. A. M. A., Sept. 6, 1919, p. 770).

—————R—————

A. P. H. A. to Meet in New Orleans

The next annual meeting of the American Public Health Association is to be held at New Orleans, Louisiana, October 27-30 inclusive. The central themes of discussion will be Southern health problems, including malaria, typhoid fever, hookworm, soil pollution and the privy, etc.

The general belief among the health profession is that influenza will return next winter, and a full session will therefore be devoted to this subject for the purpose of developing methods of control.

A special effort has been made to arrange the program to meet the practical needs of health officials. Accordingly there will be discussion on such questions

as the attitude of legislators towards public health, the obtaining of appropriations, co-operation from women's clubs, health organizations, etc., the organization of health centers, and so on.

The programs of the sections will, as usual, deal with public health administration, vital statistics, sanitary engineering, laboratory methods, industrial hygiene, sociology and food and drugs.

Two special programs will also be presented on various phases of child hygiene and personal hygiene.

Winter railroad rates to New Orleans will be in effect from all points after October 1.

The program of the meetings will be published in the *American Journal of Public Health* appearing October 5 or may at that time be had upon application to the Secretary, 169 Massachusetts Avenue, Boston, Massachusetts.

BOOKS.

The Health Officer.

By Frank Overton, M. D., D. P. H., Sanitary Supervisor, N. Y. State Department of Health and Willard J. Denno, M. D., D. P. H., Medical Director of the Standard Oil Company. Octavo of 512 pages with 51 illustrations. Philadelphia and London: W. B. Saunders Company, 1919. Cloth, \$4.50 net.

The author says, "This book contains the information which the average health officer must have in order to discharge his duties." There are five hundred pages of it and it contains a great deal of interesting information. It is needless to say a great many health officers would be more efficient if they knew all this book contains. The health officer himself is made the subject for some very comprehensive statements. "A health officer is a public educator, and his success will depend largely in his ability to make the public understand the reasons for his acts and advice." "He will be active in medical societies and will take every occasion to promote good fellowship among physicians." "He is a combination of health commissioner, medical expert, clerk, plumbing inspector, legal adviser, and chief of the sanitary police."

The author is, perhaps, a little more positive in his treatise on influenza than are the contributors to the current literature of today. He says, "Influenza and the grippe are terms that are applied loosely to any form of acute respiratory disease that is not evidently pneumonia, but they very properly refer only to the sickness that is produced by the influenza bacillus."

Very careful attention is given to epidemiology and the rules to be laid down for the control of the routes of infection are explicit and should be efficient. The author takes an extremely common-sense attitude in the chapter on venereal disease. He does not agree with those ultramoralists who would proscribe all prophylactic measures against these diseases.

Don Quixote of Psychiatry

By Victor Robinson. 340 pages with 30 illustrations. Published by the Historical-Medical Press, 206 Broadway, New York.

This is a sort of a biographical sketch of a man who, if we are willing to accept the author's version of his life, hardly meets the requirements for an historical character. The story, however, is rather pleasantly told in spite of the fact that the author so frequently forgets his subject in recounting the antecedents, lives and characters of the men at various times associated with him. We are told that Dr. Clevenger, the subject of the sketch, after trying every vocation that seemed to offer an opportunity for work, finally determined to study medicine. He entered the Chicago Medical College and at this point in the biography the author gives us the early history of Chicago, the life of Dr. Brainard and the early history of Rush, and all the men connected with the school, the break, and the founding of the Chicago Medical College, then the life sketches of the men connected with this school, together with the dirty politics and boodling politicians infesting Chicago at the time. In all this the name of Clevenger occasionally appears, incidently, perhaps, and occasionally as a sort of a connecting link between separated facts and fancies. One

gets the impression that the author has taken Dr. Clevenger simply as an excuse to write something, and though he rather grudgingly gives him credit for considerable ability as a psychiatrist, makes up for the concession by very freely airing his faults and deficiencies.

In spite of its hap-hazard construction, the reader will find quite enough to make a fairly entertaining evening's reading. There will be nothing new to those who were at all familiar with Chicago's early medical history, nor to those who can recall the newspaper accounts of its scandalous politics. Not many, however, will accept his uncomplimentary opinions of many of the most learned and accomplished men in American medicine.

Practical Medicine Series

Series 1919, comprising eight volumes on the year's progress in medicine and surgery, under general editorial charge of Charles L. Mix, A. M., M. D., Chicago. VOL. II—GENERAL SURGERY, edited by Albert J. Ochsner, M. D., F. R. M. S., L. L. D., F. A. C. S., Major, M. R. C., U. S. A., etc. Price of the volume, \$2.50; price of the series, \$10.00. Published by the Year Book Publishers, 304 Dearborn St., Chicago.

This volume covers such advances as have been made during the preceding year, in the whole field of surgery. It is especially interesting because of the material which has been produced by the surgeons who worked with the allied armies. It has of course been necessary to present the facts set forth with such conciseness as is possible. Those who have been adding the Year Book to their libraries each year will find reason to congratulate themselves on receiving this volume.

The Medical Clinics of North America

Volume III, Number 1. (The Chicago Number, July 1919.) Octavo of 277 pages, 59 illustrations. Philadelphia and London; W. B. Saunders Company, 1919. Published Bi-Monthly; Price, per year: Paper, \$10.00; Cloth, \$14.00.

The Chicago number of the Medical Clinics of North America (July 1919) probably presents a greater variety and number of subjects than any number yet published. There are some very interest-

ing clinics and some very admirable short articles.

The clinic by Ralph C. Hammil includes a case of cerebral lues to be differentiated from encephalitis lethargica, neurologic findings in a case of ethmoiditis, and a consideration of the causes of apprehension. The latter furnishes material for a considerable discussion of the subject. A clinic by Williamson includes a case of gout which is discussed in all its details.

Sansum presents a very readable and a very instructive paper on the treatment of constipation.

We have mentioned only a few of the articles in this number of the clinics and perhaps not the most interesting, but these alone are worth the price of the volume.

—R—

The Surgical Clinics of Chicago

Volume III, Number 4, (August, 1919.) Octavo of 227 pages 116 illustrations. Philadelphia and London; W. B. Saunders Company, 1919. Published Bi-Monthly; Price, per year: Paper, \$10.00; Cloth, \$14.00.

The most prominent feature in the Surgical Clinics of Chicago, August, 1919, is a series of clinics by surgeons connected with General Hospital No. 28, Ft. Sheridan.

Among these we not particularly the clinic by Major Nesselrode in which he describes the closure of cranial defects by osteoperiosteal grafts taken from the tibia, and a tibial transplant for ununited fracture. These reports are excellently illustrated. Besides the clinic by Nesselrode there are in this group clinics by Dean Lewis, Phemister, Ryerson, Pollock, Norris and Reich. Bevan has a clinical report in the August number which includes a case of brain tumor, a case of multilocular cystadenoma of the liver and a case with an epithelioma of the lower lip. There are also clinics by A. J. Ochsner, Eisen-drath, Davis, Meyer and Moncrieff, McKenna, Kretschmer, Moorehead, Speed, E. H. Oschner, Gatewood, McWorter and Reed.

—R—

The man who gets easy money pays the biggest price.

SOCIETY NOTES.

NORTHEAST KANSAS MEDICAL SOCIETY

Notice has just been received from the Secretary that the Northeast Kansas Medical Society will meet in Atchison on October 30. The program is not yet complete but we are assured that those who attend will be well repaid for their time and trouble. The officers are: President, H. L. Charles, Atchison; Vice-President, C. H. Koentz, Onaga; Secretary-Treasurer, J. L. Everhardy, Leavenworth.

GOLDEN BELT SOCIETY

The quarterly meeting of the Golden Belt Society was held in Manhattan, at the Kansas State Agricultural College, on Thursday, October 2. The following papers were presented: :

"Some Dietary Problems in Febrile Conditions," Elizabeth Rothermell, Associate Professor of Foods, Economics and Nutrition, K. S. A. C.

Subject not given, Dr. J. D. Riddell, Salina, Kansas.

"Clinical Syndromes Involving the Thy-mus," (with lantern slides), Dr. G. H. Hoxie, Kansas City, Missouri.

"Iritis," Dr. Geo. H. Ross, Manhattan, Kansas.

"Vesical Calculi," Dr. Alfred O'Donnell, Ellsworth, Kansas.

HARVEY COUNTY MEDICAL SOCIETY.

The Harvey County Medical Society met with Dr. R. S. Haury Monday evening, October 6, following a supper at Murphy's. Thirteen doctors were present.

Dr. J. T. Axtell read a paper upon the subject of "Hospitals, Religious, Municipal and Private." He stated that hospitals made for better work as physicians became more competent by team work, by association and by better equipment. The paper urged the building of good hospitals in every good town or county of the State. He approved of churches building and conducting hospitals, but where this could not be done, the county should build the hospital under the State Law. If both

these should fall, doctors and business men should get together and build private hospitals. The education of nurses would be a great factor in promoting the public welfare in the protection of children, school inspection, efficient public health service, insuring pure food, safe milk, pure drinking water and better sanitation.

The subject of Dr. Haury's paper was "Abdominal Operations under Local Anaesthesia." Dr. Haury advanced the opinion that more operations will be done under local anaesthesia when the surgeons make themselves more proficient in the proper methods of using it. He claimed for it greater convenience, comfort and safety for the patient.

A general discussion of both papers followed. After an informal discussion of the use of vaccines for the prevention or cure of influenza or "flu" the following resolution was unanimously adopted:

"Whereas, The use of vaccines for the prevention or cure of influenza is not recommended by the United States Public Health Service, and that in the present state of our knowledge is not proven to be beneficial; therefore, be it

"Resolved, That the Harvey County Medical Society does not endorse their use."—FRANK L. ABBEY, Sec.

—R—

FINNEY COUNTY SOCIETY.

The physicians and surgeons of Garden City met on September 19 for the purpose of organizing the Finney County Medical Society with the following charter members: Drs. S. Stevens, S. Bailey, J. B. Edwards, W. J. Stilson, Chas. Rewerts, Oliver Minor, R. E. Gray, T. F. Blanke, A. R. Knapp, W. R. Mitchell and R. M. Troup.

A committee on Constitution and By-Laws and a committee on Program were appointed.

The following officers were elected: President, W. J. Stilson; Vice-President, Chas. Rewerts; Secretary, R. M. Troup; Treasurer, T. F. Blanke.

Application has been made to the Kansas Medical Society for a charter.

Influenza Warning

Even though the re-occurrence of influenza this fall is still a matter of opinion, it behooves us all to be prepared in every way to crush the very first evidences of another epidemic. Thorough prophylactic measures should be put widely in force everywhere with the first case which appears. Only in this way can we prevent its rapid spread and consequent suffering.

Probably the greatest prophylactic measure developed during the last epidemic was Dakin's remarkable antiseptic, Dichloramine-T. Previous investigations by military medical men had demonstrated its power to prevent infectious diseases originating in the upper air passages, such as meningitis, diphtheria, etc., and had shown its ability to clean up diphtheria carriers.

Its use as a spray to the nose and throat to prevent influenza was therefore perfectly logical. Thousands of people, in some cases the entire working force of large industrial plants, received sprays twice daily to nose and throat of a two per cent solution of Dichloramine-T in Chlorcosane. Also they were instructed to use a gargle Chlorazene, Abbott, 0.25% solution every two hours and before entering street cars or other public places.

The results were gratifying. Wherever these measures were carried out the incidence of influenza was unusually small. Further information on the uses of Dichloramine-T and Chlorazene may be obtained upon request to The Abbott Laboratories, Chicago, Illinois.

Proper Storage of Biologicals

One of the most important features in the sale and distribution of biological products is the proper storage of serums and vaccines between the time of final test and shipment to customers.

In addition to the large cold storage capacity at the Glenolden Laboratories for the preservation of biological stocks, ample provision has been made for the maintenance of suitable temperature for biological products in the new Mulford build-

ing, Philadelphia, which is being occupied as quickly as conditions will permit.

Two large rooms have been constructed for unfinished and finished stocks, with a capacity of 50,000 cubic feet, in which a minimum low temperature will be maintained. Small vestibule apertures connecting with the foreign and domestic departments permit the delivery of stock without opening the door and affecting the temperature.

Within the finished stock room is a compartment especially designed for the storage of smallpox vaccine, in which a temperature of about 25 degrees F. is maintained.

It has always been the aim of the Mulford Company to deliver biologicals to its distributors in perfect condition, so that if placed immediately in the refrigerator when received by the druggist, ideal results may be expected from their use.

Government Wants Workers in Venereal Disease Campaign

The recently created Interdepartmental Social Hygiene Board of the United States Government is in need of a number of specially trained men and women to complete its organization. The United States Civil Service Commission has announced examinations for the following positions: Chief of division for scientific research, \$3,500 to \$4,500 a year; chief of division for educational research and development, \$3,500 to \$4,500 a year; educational assistant, \$2,800 to \$3,600 a year; chief of division of relations with States, \$3,500 to \$4,500 a year; chief of division of records, information and planning, \$3,500 to \$4,500 a year; supervising assistant and inspector, \$2,800 to \$3,600 a year; field agent, \$1,800 to \$3,000 a year. All positions are open to both men and women.

Applications for these positions will not be given scholastic tests in an examination room, but will be rated upon their education, experience, and writings. Published writings of which the applicant is the author will be submitted with the application. For most of the positions a thesis:

on one of a number of given subjects will be accepted in lieu of published writings. The receipt of applications will close on November 4. Detailed information and application blanks may be obtained from the United States Civil Service Commission, Washington, D. C., or from the secretary of the United States Civil Service Board at the post office or custom house in any of 3,000 cities.

The law creating the Interdepartmental Social Hygiene Board provides for the cooperation of the War and Navy Departments and the Public Health Service of the Treasury Department for the prevention, control, and treatment of venereal diseases. The duties of the Board as set forth in the act are (1) to recommend rules and regulations for the expenditure of moneys allotted to States for the use of their respective boards or departments of health in the prevention, control, and treatment of venereal diseases; (2) to select universities, colleges, or other suitable institutions which shall receive allotments for scientific research for the purpose of discovering more effective medical measures for the prevention and treatment of venereal diseases; (3) to recommend such general measures as will promote correlation and efficiency in carrying out the purposes of the act; and (4) to direct the expenditure of certain moneys appropriated by the act.

—————R—————

The Uses of Yeast

Yeast is one of those remedies that have undergone alternating cycles of use and of disuse. Just at present it appears again to be in its ascendancy. Recently renewed attention has been called to its laxative qualities. The much debated question whether yeast can be used as a food, can be answered in the affirmative. However, in view of its laxative action, the amount of yeast which can be ingested is limited. Also, owing to its high nuclein content it is contraindicated in gout. As a source of water soluble growth promoting as well as antineuritic vitamin, yeast has become thoroughly established. However, as com-

mon foods contain this vitamin, there is little likelihood of its proving of therapeutic value, since it promotes growth only when stunting is due to lack of vitamins. Yeast has been used as an application in acne, for infected wounds and in leukorrhea. Recently the curative value of the oral administration of yeast in various cutaneous disorders has been reasserted. (Jour. A. M. A., August 23, 1919, p. 628.)

—————R—————

A Cheese

Some cheese! If you don't believe it here are the facts, for it is the largest cheese in the world; and it was made for Armour and Company, Chicago::

Weight, 31,964 pounds.

Height, 8 feet.

Diameter, 10 1-2 feet.

Circumference, 33 feet.

Value, \$16,000.

Weight of container, 8,000 pounds.

Milk used, 357,500 pounds.

Salt used, 800 pounds.

Rennet used, 1,251 ounces.

Three bandage cloths used, valued at \$260 each measuring 33 feet long and 16 feet wide.

Factories furnishing the curds, 59.

Made by 73 cheese makers and helpers.

Value of cheese factories about \$400,000.

Milk taken from 12,000 cows on 1,800 farms.

This cheese, larger than any ever attempted before, was made to be exhibited by Armour and Company at the National Dairy Show to be held at the International Amphitheatre October 6 to 12th, 1919.

So big and unique is this huge cheese that motion pictures have been taken by two large film companies, which will circulate the pictures of the world's largest cheese throughout the world as well as the process of manufacture.

—————R—————

Third Survey of Hospitals

The third survey of hospitals being made under the auspices of the American Medical Association is now well under way. Through an extensive correspondence and a third questionnaire the Association has

collected a mass of information on the subject. Much of this material has been tabulated and forwarded to committees in each state representing the state medical associations. Most of the state committees have arranged definite lines of action and by inspection of the hospitals or by other methods are securing first hand information by which the data collected by the Association is being carefully checked. The immediate end sought is to provide a reliable list of hospitals which are in position to furnish a satisfactory intern training. The investigation is not limited to intern hospitals, however, but will cover all institutions and the data obtained will be useful in any future action which may be taken in classifying hospitals. The work in Kansas is in charge of a committee the members of which are Dr. J. L. Moorhead, Dr. H. L. Snyder and Dr. Geo. M. Gray. The closer relationship which the hospital now bears to the public in the community which it serves makes it all the more important that the service rendered by it shall be excellent in character.

—R—

Physicians Wanted for Epidemic

The following circular letter has been sent out from the office of the State Board of Health. We are informed that about fifty have signified their willingness to serve in case services are required, but a much larger number will probably be needed:

"Dear Doctor: During the epidemic of influenza last winter there were many communities absolutely lacking in medical attendance. In collaboration with the U. S. Public Health Service we tried to remedy this by securing a list of doctors willing to help where needed.

"This year, as a matter of preparation, we are asked to secure a similar list of physicians willing to be at the call of the U. S. Public Health Service for special duty in influenza cases, it being understood that they are to be used in this state and as far as possible in their own community. The terms are \$200 per month salary, plus \$4 per diem subsistence, and actual traveling expenses.

"In last year's pandemic there was terrible need of physicians for this service.

Kansas doctors responded, to the best of their ability, to our call for help. So many men were absent in army and navy service, however, that the response was necessarily limited. Now that you younger men have come back again to home fields, we expect to be better supplied.

"Please let us know, by return mail, if we may put your name on our list of volunteers to fight influenza under the conditions and terms named above. Fraternally,

S. J. CRUMBINE, M.D.,

"Collaborating Epidemiologist,
U. S. P. H. S."

—R—

Tuberculous Infection of Rabbits After Experimental Artificial Pneumothorax

In an endeavor to obtain tuberculosis of only one lung, F. W. Shaw of the William Volker Research Laboratory, Kansas City, first performed artificial pneumothorax of one side in rabbits and then infected the animals both intravenously and intratracheally. The author was surprised to find that visible tubercle developed only in the collapsed lung, while the functioning lung was apparently spared. He thinks that his experiments show that the collapsed lung is not a defense against the tubercle bacillus.—American Review of Tuberculosis.

—R—

In the page advertisement of the Gilliland Laboratories, of Ambler, Penn., in our September issue, the price of 1,000 units of Diphtheria Antitoxin was printed \$0.75. If this was capable of being misunderstood, this notice is intended to correct such misunderstanding. The price of 1,000 units is 75c.

—R—

The Oldest Irish Joke

Pat was down and out. He concluded to commit suicide. Later he was found dangling in the air with the rope around his body. A passer by asked him what he was doing. "Faith an I'm committan suicide." "You can't do it that way, Pat. Put the rope around your neck," said the passer by. "Indade," says Pat, "I tried it that way but I couldn't breathe."



*Our advantages make us headquarters
for the organo-therapeutic products*

Doctors Should Specify

In a paper on Corpus Luteum in the New York Medical Journal, Dr. Sajous states:

"The two most important prerequisites to success in the use of the drug appear to be:

"1. The selection of a preparation made exclusively from the corpora lutea of pregnant animals, and

"2. Due attention to the fact that the action of the drug is frequently slow in asserting itself and that the drug should be given up only when thorough trial has demonstrated its lack of efficiency"

Corpus Luteum (Armour) is made from true substance. The glands are gathered in our abattoirs and we know what we are using.

Corpus Luteum (Armour) is supplied in 2-grain capsules, bottles of 50; 5-grain capsules, bottles of 50; 2-grain tablets, bottles of 100.

Specify *Armour's* and you will get the best the market affords.

ARMOUR AND COMPANY
CHICAGO

Pituitary Liquid—
is physiologically standardized and is free from preservatives.

1 c. c. ampoules, boxes of six.

Thromboplastin solution, 25 c. c. vials.

Thyroids—
Standardized Powder; Tablets, 2 gr., 1 gr., 1-2 gr., 1-4 gr.

Parathyroids—
Powder and Tablets, 1-20 grain.

Pituitary, Anterior—
Powder and Tablets, 2 grain.

Pituitary, Posterior—
Powder and Tablets, 1-10 grain.

Grandview Sanitarium

KANSAS CITY, KANSAS

The Grandview Sanitarium was completely destroyed by fire; Fifteen years active work in the sanitarium business enabled us to know our needs for the future. We have planned, built and completed what we believe to be an ideal place and are open and ready for business. Thanking our friends for their patronage in the past and assuring you we are prepared to give as good service as can be had in any sanitarium, we remain,

Very truly yours,

S. S. GLASSCOCK, M.D., Res. Supt.

A. L. LUDWICK, A.M., M.D., Asst. Supt.

EDITH GLASSCOCK, B.S.

Business Manager

Office 910 Rialto Bldg., Kansas City, Mo.

A Modified Application of the Rationale of Fresh Air Treatment

According to Baruch, whatever benefits are derived from fresh air treatment are due to vasomotor stimulation by the movement of outdoor air at the proper temperature. This stimulation is beneficial to all the organs that receive it reflexly. The physiological effect of cool air and water is similar although the latter, because it transmits its temperature to the skin twenty-seven times more rapidly than does the air, provokes a much more rapid and active response. Exposure of the body to water can therefore be used for the same therapeutic purposes as exposure to fresh air; and vasomotor stimulation by judicious water treatment enhances the fresh air effect so much that the final result is improved at least 50 per cent by its addition to the other treatment. The procedure should be mild and methodical, and beneficial results are to be obtained only by supervision and close attention to details, which the author is careful to particularize.—American Review of Tuberculosis.

—————R—————

Some of the members of the St. Louis Medical Society have organized a section of that body called the Clinical Section of the St. Louis Medical Society, and have established a system of clinics to which members of our association are invited when they are in St. Louis. The advertisement appears in this issue under the heading Saint Louis Clinics. There is a large amount of clinical material in St. Louis which has never been organized, but now should afford splendid opportunities for physicians who desire to take advantage of the arrangement.

—————R—————

Whiskey served by a physician appears to be less harmful than when served by a barkeeper.

—————R—————

Dietitians tell us that one quart of milk contains as much solid nourishment as a pound of beefsteak.



Best Fitted to Digest

Puffed Wheat and Puffed Rice are whole grains steam exploded. Corn Puffs are corn hearts puffed.

The process was invented by Prof. A. P. Anderson, formerly of Columbia University. The object is to blast all food cells for easy, complete digestion.

Ordinary cooking breaks part of the food cells. This process breaks them all. And it makes grain bubbles, thin and flimsy, with a delicious taste.

These delightful grains, cooked, toasted and exploded, are the best-cooked cereals in existence.

The Quaker Oats Company

Chicago

**Puffed Wheat
Puffed Rice
Corn Puffs**

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Post Operative Use of Radiant Heat

L. A. SUTTER, M.D., Wichita, Kan.

Read at the Annual Meeting of the Kansas Medical Society held at Ottawa, Kansas, May 7 and 8, 1919.

There are a number of reasons why mechanical therapeutics have not been more widely used by the general surgeon. Probably the foremost is, he is usually skeptical of things he has not tried himself or of those not recommended by a teacher in the medical school or the hospital where he was an interne. Then again, fadists, quacks and charlatans have so overdone all claims for mechanical appliances in medicine, that the general surgeon tries to keep away from any of their claims.

However, for a number of years many of the leading hospitals and sanitariums have made use of heat by other means than a hot water bottle.

The sun's rays have been utilized in the treatment of tubercular bone disease to a very great extent in Switzerland. And in many sanitariums the electric light has been used for many years for the treatment of arthritis, sciatica, lumbago, etc., but it is only recently that radiant heat has been used in the after care of surgical cases by some of the best surgeons of this country.

WHY RADIANT HEAT IS BETTER THAN HOT WATER BOTTLES

In applying heat to an inflamed or painful area the rubber or metal bottle filled with hot water is universally used. Here heat is applied in a dry form and it does not penetrate the surface until it has extended laterally by convection and it does not penetrate to any great depth below the surface. Moist heat will relieve

pain better than dry heat, but it is difficult to get moist heat applied in such a manner that the heating apparatus will not cool too quickly. Then again, fermentation can hardly be applied over dressings on an operative case without more or less soiling them. Heat, however, from the electric lamps can be easily applied by anyone. There is no danger of soiling the dressings. The light rays also produce heat much more quickly than the hot bottle or fermentation and the rays penetrate below the surface of the skin to the depth of an inch or more. The light rays produce a stimulation of the vasomotor nerves below the surface while dry heat from a bottle will affect the vasomotors of the skin only.

THE THERAPY OF HEAT

Heat if applied for a very short time may have an intrinsic effect, but when applied for a greater length of time it has a more marked reactionary effect.

"There are two important phases of reaction, namely, the circulatory and the nervous. The circulatory is the most apparent and it is that by which we judge the completeness of reaction. The patient feels a warm glow over the skin surface. The nervous reaction is appreciated not only by the patient, but by the observer as well. There is a brightening of the eye and countenance. A delirium may be replaced by quiet sleep." G. K. Abbott's *Hypertherapy for Practitioners*.

Pain is usually due to congestion of a part. Not only is there a disturbance of the blood flow through the part, but there is a lymphatic stasis. Heat causes an initial vaso-constriction, but when con-

tinued brings on a passive hyperemia. It is this tonic and depressing action of heat that aids in the elimination of pain by lessening the pressure in the part. It also increases phagocytosis by bringing more white cells to the area and probably it stimulates them to greater activity. At the same time the light rays from electricity or the sun have somewhat of a bactericidal action.

WHERE RADIANT HEAT MAY BE USED

Dr. Crile has used the radiant heat for a number of years in treating infected cases and has been well pleased with his results.

A. J. Ochsner, in *Surgery, Gynecology and Obstetrics*, volume 27, page 328, has the following to say in regard to electric light:

"Four years ago, when I suffered from a violent infection of my elbow, it became necessary to expose the ulnar nerve when the abscess was laid open. This gave rise to intense neuralgic pains which continued for many days without cessation, notwithstanding the use of wet and dry heat.

"At the suggestion of Dr. Saurenhaus, I applied an electric apparatus. Within an hour the pain had disappeared, not to return.

"My natural skepticism regarding the effect of therapeutic measures led me to think this might be due to coincidence and that possibly the pain might have subsided at this time had we not employed the electric light.

"During the past four years, however, I have had an opportunity to test this method at the Augustana Hospital in 78 similar cases of infection of the extremities, and invariably the pain has disappeared promptly.

"We have had equally satisfactory results in the use of the electric light in treating peritonitis following abdominal sections for the relief of suppurating conditions such as appendiceal abscesses, perforated gall bladder, also in tuberculous and gonorrheal joint infections, in carbuncles and furuncles."

I have used radiant heat for a number

of years on a great variety of cases and I am satisfied that it not only lessens the pain after a great many operative procedures, but it also hastens the healing in infected cases.

A colleague of mine had a case where the knee joint was resected for tuberculosis. The patient suffered excruciating pain. At my suggestion, he begun the use of electric light to the involved area. The patient experienced material relief from her pain every time the light was applied.

I wish to report two cases in which I have recently obtained excellent results from the use of electric light. The first: Mr. F's little finger was caught between the forms while making cement tile. The soft parts were cut entirely through for an inch on the palmar surface and across the radial surface of the little finger, the back of the finger was very severely mashed. A virulent *strepptococcus* infection was the result. His hand and forearm became greatly swollen and the swelling extended up the arm nearly to the shoulder. The pain was so severe that he could not sleep. It required opiates to keep him from continuously moaning. Hot moist dressings were used without any results. The arm was put in a bath with the temperature as high as he could stand, but it would not relieve the pain or muscular contractions of the hand to any great extent. Then we tried the electric light. This we would apply for an hour at a time, using two 70 watt incandescent lamps with a tin reflector. The radiant heat would not only relieve his pain, but it would seem to lessen the muscular contractions in the hand so his fingers were not drawn so tight. After applying the heat there was a much freer discharge from the various openings in the arm and the patient said that the relief afforded was not to be compared to anything else we had done for him. The arm at the present time is well and the patient has been discharged from the hospital.

The second case is that of an abdominal operation in which I removed a large infected cyst involving the left tube, ovary

and broad ligament. A few days after the operation, we applied the radiant heat twice daily, for an hour at a time. You could see a marked diminution of the pus each day and the pain, according to the patient's statement, would be entirely relieved at each application of the light.

I now use the electric light in all infected cases and I feel that it not only hastens repair, but the patient is made a great deal more comfortable by its use.

HOW TO MAKE A RADIANT HEAT APPARATUS
Have a tin smith make a box out of bright tin, about 14 inches long, 6 inches wide at the top and 8 inches deep. The can should flare out at the open side to about an 8 inch width. In the bottom of this can two or more sockets can be soldered for incandescent lamps. All that is necessary is to put in two or more 60 watt lamps and a cord to connect the electric supply. The bright tin acts as a reflector focusing all the rays of the lamps on the area to be treated.

CONCLUSION

1st—The electric light is the most convenient form in which to apply heat.

2nd—Electric light penetrates below the surface much deeper than any other form of heat.

3rd—It relieves pain after a great many surgical procedures.

4th—It helps to hasten the subsidence of pus and hastens the healing in infected surgical cases.

—R—

Personal Experience With Gas in the St. Mihiel and Argonne-Meuse Drives

By REGINALD H. MEADE, Major M. R. C.,
354th Infantry, 89th Division

Read at the Annual Meeting of the Kansas Medical Society held at Ottawa, Kansas, May 7 and 8, 1919.

The subject of war gasses will, I hope, not demand much attention in the future, and the only excuse I have for bringing this subject before you is that I have been asked to do so by your secretary.

My experience with gas attacks was confined to attacks caused by throwing over gas shells by artillery. These shells, in addition to being charged with high ex-

plosives, contain a liquid which, when the shell explodes, is scattered broadcast over the ground, is atomized and spreads as a mist through the air and forms a liquid film upon coming in contact with solid substances.

Casualties are produced in two ways, by inhalation of the atomized mist and by handling of articles covered with the liquid film. The gas penetrates the clothing and is inhaled by the men. The film collects on solid substances, such as artillery, rifles, clothing and equipment. Most of the men in the Medical Detachment were injured by having to work on the gassed men in the front lines without proper facilities.

Certain localities on the body are more susceptible to burns. Areas that are prone to sweat are the most susceptible, as the axilla, groins and genitals. A very common manner of body burns was due to the fact that a soldier would protect his air passages with his gas mask, but would have a desire to urinate and in handling his genitals would receive severe burns from the gas on his hands. Another common occurrence was to use for a latrine an old shell hole where gas vapor had remained, and in sitting over this there would be severe burns of the buttocks.

Clinical observations of mustard gas lesions of the respiratory tract cover injuries to the epithelium of the mucosa of the upper respiratory tract, particularly of the anterior nares, hard and soft palate, dorsum of the tongue, pharynx, larynx and upper part of the trachea.

The most common symptoms in soldiers exposed to light and moderate concentrations are conjunctivitis, rhinitis, laryngeal huskiness, cough, sore throat and excessive thirst. Recovery from these conditions is usually prompt. Huskiness and cough may continue for weeks in the more severe exposures where there is a greater degree of degeneration producing necrosis of the epithelium extending into the bronchi and causing a widespread catarrhal trachitis and bronchitis with congestion and edema of the lungs. More severe exposures produce diphtheritic lesions of the larynx,

trachea and bronchi, terminating in bronchopneumonia.

The gastrointestinal symptoms are claimed by Warthin to be probably reflex, associated with shock or respiratory irritation. In most cases of moderate gassing the patient is nauseated or vomits.

The early eye symptoms consist of a burning with irritation of the conjunctiva and lacrimation followed by severe pain and photophobia, the patient having to be led around.

In my own case I would describe the symptoms: first, a burning sensation in the eyes, marked photophobia, a tickling sensation in the nose and throat, a painful cough, worse at night, in twenty-four hours the voice became husky and was later nearly lost, it being difficult to talk above a whisper, and inside of a week pain under the sternum which was like angina on the least exercise, being rather severe for about two months and then gradually growing less. This symptom was still present seven months later. The cough lasted about five months. The eye symptoms disappeared in two weeks. The voice returned to normal in about five weeks.

The X-Ray picture of my own lungs showed an extensive fibrosis of both lungs, especially the right. These changes so simulate the picture of a fibrosis in tuberculosis that it is by no means easy to differentiate. One possible difference noticed by an expert in interpreting X-ray pictures is the absence of the characteristic cone-shaped shadow in tuberculosis. I had an opportunity, while at Limoges and Beau Desert, to examine many X-ray pictures of gassed lungs and about the same condition existed to a greater or less degree.

A diagnosis of inhalation gas should never be made in the absence of conjunctivitis. It was generally proved when cases came with laryngitis and bronchitis in the absence of conjunctivitis that they were never caused by gas, but by ordinary colds. It was an excuse used many times

by men hoping to be evacuated to the rear to a hospital.

Gas alarms are made with klaxon horns and by shouting "Gas." These alarms are used principally by new organizations going into the fighting line whose experience with gas consists of a course of instruction in one of the so-called "Gas Schools." There you learn that one whiff of gas, if it does not kill you instantly, will cause you to die a lingering death, and the sentinels from a new organization will give the gas alarm any time they hear a shell go over. This was the case around Headquarters at Noviant, where three or four times during the night a gas alarm would be heard and every one would have to jump up and put on his gas mask, only to find later that there had been no gas. This did much to demoralize the Regiment, and instead of punishing the men for not giving gas alarms as taught in the schools, it became necessary to punish sentinels for giving gas alarms when there was no gas.

To the inexperienced there is no more horrible thought than to sit at midnight with a gas mask on and think that all around you are fumes that would kill you instantly if you had your mask off, and you begin to get panicky and feel that if you don't take it off soon you will suffocate. At least that is the sensation you have on your first experience, and a number of men take off their masks in this panicky stage. If one will go through this stage which only lasts a few seconds, he soon becomes accustomed to his mask. I have gone to sleep with mine on. When a gas alarm is given, some men become hysterical and have to be restricted to keep their masks on, especially if they get a whiff of gas which gives them a sense of suffocation. Gas demoralizes men much more than any other kind of an attack, much more than the so-called "going over the top."

It is at times quite difficult to tell whether or not the enemy is using gas, but in any German attack lasting ten minutes or longer gas was used. The peculiar sound of gas shells can only be ap-

preciated after hearing them. They have a squashy explosive sound, quite different from high explosives, but duds sometimes fool you when they light in mud.

The odor of mustard gas is to me nothing like mustard. It can not be described, it has to be smelled; but once smelled, it can never be forgotten. It has a peculiar pungent odor more like garlic. Phosgene has a sweetish odor not unlike the high explosive, and it was quite hard to differentiate. The high explosive causes sneezing also, but is apparently harmless. You were never sure which you were getting and had to resort to your gas mask.

The gas used by the Germans in their last attacks was much more effective than before open warfare was started, owing to the fact that there was no chance for protection in the form of protected dugouts.

The 89th Division had an introduction to gas soon after it was placed in the line. We relieved the 82nd Division in what is known as the Toul sector. Our Regiment, the 354th, had its headquarters in Noviant. In front of this village were two tracts of woods that hid us from the view of the enemy. The little torn up village of Flery was on the Metz road and about two miles in front of Noviant. Our trenches ran for some distance in front of Flery, while the enemy trenches were on higher ground and they had a good view of the Metz road and Flery. About a half mile back of Flery there was a deep hollow with well wooded hills on both sides that gave us perfect protection from observation by the enemy and protection from artillery shells as we could dig into the bluff in front of us and be perfectly safe except for a direct hit. This terrain made it a dangerous place for gas shells as the ground was low and many men were always there on account of the protection offered by the hills. Rolling kitchens, first aid stations and command posts were all located here. We found many dugouts in this place which had been built by organizations preceding us.

On the night of August 7th, between the hours of nine and twelve, 8000 yellow cross

shells were thrown in this hollow by the Germans. Apparently there was no harm done as everyone stayed in his wet blanket-dugout, and not until the next morning at five A. M. did any one realize what had happened. A few men had passed through this area with slight eye burns, but no particular attention was paid to it until daylight when the men began to move about in this area. There were 1,000 casualties in the Division and 250 of them were in our regiment. These were due to the fact that neither officers nor men had been instructed in this method of gas warfare, and the men were not evacuated from the gassed area as they should have been.

When I arrived in the gassed area, I saw the most horrible sight I have ever witnessed. Men were lying around on the ground with their eyes covered to protect them from the light, and were vomiting and begging for relief. These men had been working for several hours in the gas, as it takes some time for it to take effect, when suddenly they would complain of nausea, conjunctivitis, laryngitis, and the sense of suffocation. It seemed a most stupid thing for this to have been allowed to happen, especially as the two officers from headquarters, sent out for inspection of the trenches, were gassed, also two battalion commanders and the two gas officers; but this was the first attack of this particular kind, and the training our men had was done by officers who had never been in a gas attack, and again, as in all successful attacks, it was a surprise. We had an expensive but valuable lesson. We learned that there were many things to do beside put on a gas mask, the most important of which was to evacuate the gassed area.

On the afternoon of August 8th, following our first gas experience, having completely evacuated all of our gassed men from the first aid station, I went back to a field hospital to check on some of our men. This was a tent structure. Every available bed had been taken, and the ground around in a small woods was lit-

erally covered with the casualties of the entire Division caused by this attack. All the available nurses and men were bathing the eyes of the patients whose chief complaints were severe pain in the eyes and vomiting. The men were being undressed and given a soda bath as rapidly as possible. Their suffering seemed to be greater, judging from the groans to be heard all over the woods, than any other suffering from wounds witnessed by me later. Fortunately, in wounds received from high explosives and machine guns, the suffering is not very great as compared with the suffering endured from gas.

In the St. Mihiel drive of September 12th we were not bothered to any extent with gas until after we had reached our objective, the Hindenburg line. It was then necessary for the men to dig themselves in and to use cellars and such other protection in the little villages as we could get. We were located in woods and small villages, both of which are favorable for the enemy gas attacks. So here again the Germans started their malicious demoralizing attacks, and there was no day that we did not evacuate gassed casualties.

On September 27th, in the little village of Xammes, the Germans gave us a continuous mustard gas attack for two nights and one day. The medical detachment was located in an old wine cellar, there having been no preparations made for holding this line. Our cellar soon became fairly well saturated with gas, both from explosion of shells outside and from casualties bringing it in on their clothing. Despite all our efforts, building fires, using fans and wearing gas masks, a number of the medical detachment men was gassed, including myself, not severely enough in my case, however, to warrant leaving the regiment.

On November 1st, the date of the Bantheville Woods attack, it was necessary for the surgeon to go over behind the first wave and establish a dressing station at Dhuy Farm which had been occupied two hours before by the Germans. A stubborn resistance was being made to keep us

from occupying this farm as it was on a rock road and would give us an opportunity to get the wounded back, as well as bring up supplies. So they were making severe attacks with artillery and were throwing many varieties of gas shells.

This was my first experience with phosgene. The shells were lighting behind me to the south, and the wind was from that direction. I had a perfect horror of phosgene and you may imagine my state of mind when I suddenly stepped into a cloud of what was unquestionably phosgene, as it had been described to me as having a sweetish odor. I had been told by amateur gas teachers that one whiff of this gas was sure death. I am certain I got more than one whiff while putting on my gas mask and getting out of the cloud. After reaching safety, I took off my mask, drew a deep breath and realized that there could not be very much the matter with me. There were with me two other officers and several enlisted men, who were having the same experience. We were all surprised that we were not having more severe symptoms. It was suggested by one pessimist that phosgene gas did not kill instantly, but that most likely we had all gotten enough and would probably die a lingering death. While we suffered some discomfort from a cough that continued several days, nothing more severe developed.

On another occasion, about daylight, we were going into the village of Ramonville in an effort to locate a command post, when the enemy made an active artillery attack on this village. The first shell sent over made me realize that we were being shelled by yellow cross shells. I ran into an old cellar to escape the high explosives and found the cellar contained a lot of mustard gas. I was afraid to stay in and afraid to go out, but preferred to take my chances with high explosives rather than gas. I stood behind the biggest wall for about fifteen minutes before the bombardment let up. It was necessary to wear our gas masks for about two hours after the attack, and no cellars were allowed to be

used until all were freed from the gas.

It was soon learned by the American army than any bombarding by the German army, lasting for ten minutes or longer, was never without gas. In fact there was no day's fighting that every man in the fight did not get an opportunity to smell gas. The army had more horror of gas shell attacks than any other of the Hun's methods. We all became thoroughly familiar with the sound of the gas shell, which was very different from the noise made by a high explosive and had much more horror attached to it, as you can readily see. After a high explosive has exploded, it is through, but the gas shell remains deadly for several hours. Many times shells were thrown over on rainy nights with practically no harm done, but on the morning after, the sun coming out would cause the gas to volatilize, at once becoming deadly in an entirely unexpected way. Mustard gas, while not a killing method of warfare, gives the highest number of casualties and proves a valuable method of defence by rapidly reducing the enemy.

—R—

GENERAL PSYCHIATRY FOR THE GENERAL PRACTITIONER

3. The Treatment of Mental Diseases*

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Scientific treatment of disease has always trailed far behind scientific diagnosis. Several of our leading medical schools have had the criticism hurled at them from heavy guns that they teach the student to diagnosticate, but teach him nothing about treating the patient after he has made the diagnosis. This accusation has been levelled with great acuity and truly with some justice at the neurologists and psychiatrists. "What good is your accurate diagnosis," they are asked, "if it merely means a finer distinction for

a condition for which you offer no effective treatment?"

Fortunately for all of us, modern advance in neurology and psychiatry is controverting this old attack. The research made possible by the war in the treatment of psychoneuroses, hysteria and all its brothers and sisters and cousins, is spectacular enough, but it is not an isolated instance. The improved methods and means of treating syphilis of the nervous system have resulted magnificently, however short we may be of the goal we are aspiring for. There is scarcely room for further doubt that at least *some* cases of brain syphilis are improved greatly by modern methods of treatment, and that many cases are improved more or less. Similarly there is the advance in the proper application of electricity, heat, water, etc., in the hydrotherapeutic and mechano-therapeutic branches, and even more ardently heralded methods of treatment by occupational and recreational diversion. Great advances have been made in the treatment of the more strictly institutional types of cases, but of these we shall not more than mention.

Suffice it then to say that the neurologist and psychiatrist is no longer helpless to aid in treatment the cases he is so careful to accurately diagnose. The fact remains, however, that *accurate diagnosis must precede effective treatment.*

This sounds almost like a truism; one thinks the same might be said of most medical ailments. Perhaps so, but the case of typhoid which is first thought to be pneumonia, and treated as such until the diagnosis is altered, does not usually materially suffer. On the other hand the case of hysteria treated as an organic paralysis *does* suffer from the mistake in diagnosis, and may be rendered well nigh incurable. The case of brain syphilis treated by the mistaken diagnosis of "apoplexy" or of "senility" or "diabetes" *does* suffer, and suffers greatly. All too frequently we see cases diagnosticated "hysteria" or "epilepsy" which eventually prove to be brain tumors or abscess or syphilis which *might*

*This paper was designed originally as a discussion of the methods of treatment applicable in mental diseases following influenza. In view of the fortunate failure of materialization of the return epidemic, it was thought advisable to modify the subject toward a more general discussion of the TREATMENT of the mental diseases concerning the DIAGNOSIS of which previous papers have dealt.

have been cured had they not been mislabelled with a benign or a hopeless (and erroneous!) name. It is for precisely this reason that I have advocated that the word "Epilepsy" might well be replaced by the word "Fits", since the latter misleads no one, and stimulates attempts at treatment, while the former is apt to be incorrectly applied, and in such cases destroys hope for and attempt at treatment.

GENERAL PRINCIPLES OF TREATMENT

There are four simple general principles which apply to the treatment of diseases of the nervous system.

After ascertaining the cause (which follows from *diagnosis*)

- 1 Attempt to remove the cause.
- 2 Attempt to counteract the cause.
- 3 Attempt to alleviate the symptoms produced by the cause.
- 4 Attempt to prevent further extension of the cause or its effects.

This paper attempts to show in brief how these principles may be applied in the various forms of mental disease. It goes without saying that only the briefest outline can here be given. Two heavy volumes (by White and Jelliffe) were required seven years ago to set forth what was then known of "The Treatment of Nervous and Mental Diseases," and the advances since then would necessitate a full 100 per cent addition. Nor will any attempt be made to summarize four volumes of matter into one current article. I shall only try to point out the main methods of modern treatment applicable.

This article, as stated above, was originally conceived as a note on the treatment of the mental disturbances *following influenza*. But the fact that the expected influenza epidemic fortunately failed to materialize led the writer to modify it in the direction of greater generality. Influenza was shown to precipitate or at least to be followed by practically every known form of nervous and mental disease. Consequently an article on the treatment of post-influenzal nervous diseases would be an extremely general discussion.

It will be recalled that there were pre-

sented twelve *principles of treatment in each of the twelve groups*.

It will be recalled that there were presented twelve major groups of mental disease, into one of which any case may be fitted. The list began with *Brain Syphilis*, next came *Feeble-mindedness*, then *Epilepsy* (I would prefer to say simply *Fits*) and thereafter *Drug Diseases*, *Gross Brain Diseases*, *Deliriums*, *Mental Diseases of age*, *Schizophrenia* ("Dementia praecox"), *Paranoid Diseases*, *Mania* and *Melancholia*, *Psychoneuroses*, and *Psychopathy*.

Each of these groups may be presented as possessing certain points of attack by treatment common to the species in that group; that is to say that all of the varieties of *Brain Syphilis*, for example, may be treated according to the same generic principles of Group 1, although there will be special variations and deviations to fit the particular species of disease as well as the particular person having that disease. In other words, the *Treatment* of mental diseases may be, in general, indicated by *Groups*, just as can the *diagnosis*, and in fact these groupings correspond to the diagnostic grouping already discussed.

GROUP I. BRAIN SYPHILIS

Brain syphilis is to be treated as syphilis and then as brain syphilis. One should first use an abundance of mercuric salts, sodium iodide, and intravenous or intramuscular arsphenamine. The latter is by all means the most important. After a preliminary dose of these, if improvement does not supervene, more specialized forms of antisiphilic treatment should be considered, such as injections of serum into the spinal canal or through a trephine opening into the ventricles of the brain. These methods yield excellent results sometimes, but of course require special equipment and technique for successful accomplishment. The two important points to remember are, *Pertinacity* and *Optimism*. Some cases of neurosyphilis have only shown improvement after as many as fifty injections of arsphenamine. Yet both patient and physician should in all cases of neurosyphilis be hopeful of improve-

ment, because in cases in which treatment is begun in time, improvement and even recovery are the rule.

GROUP II. FEEBLEMINDEDNESS

The treatment of the feeble-minded child, provided a removable cause cannot be found as it sometimes can, is *segregation* and *special training*. This may be accomplished to some extent in the public schools; in Topeka we have six classes for mentally retarded children, in charge of specially trained teachers. (Of course not all of these children are feeble-minded, although many of them if not most of them are.) There are a number of good private schools for this work. And finally there is the state training school at Winfield. Children of low grade feeble-mindedness *should be committed*, and the doctor who does not strongly recommend this is at least morally responsible for the sorrow that often follows in the train of the sexually promiscuous and precocious, weak-willed, half-witted child.

GROUP III. "FITS" (EPILEPSY)

Probably more than half of all "fits" can be accounted for by some ascertained cause. These cannot be called epilepsy, although they usually are. The treatment for such, of course, is the removal or counteraction of the cause.

For those "fits" for which we can find no cause, now called epilepsy for want of a better name, we may prescribe a prophylactic and hygienic treatment which serves to decrease the frequency and severity of the attacks in almost every case. These principles of hygiene are well known to every physician; it is simply a matter of applying them. The writer in practice gives the patient a typewritten set of rules, specially prepared for each patient. These rules are such familiar edicts as "Have your teeth carefully examined by a careful dentist, with X-ray films for possible foci of infection," "Spend at least four hours every day out of doors," "Sleep out doors at night," "Insure one good bowel movement every morning at a regular hour, by following a diet of . . . etc.," "Avoid excesses of every kind, particular-

ly of exertion, over fatigue, . . . etc."

It should be emphasized that all sources of external irritation should be removed, such as family troubles, excitements, griefs, anxieties, labors, etc. In regard to medication the writer is inclined to put more faith in cascara sagrada than in bromides, although of course both may be of service. In some cases of endocrine disturbance pituitary gland has given good results, greatly decreasing the frequency of attacks. *Each case must be individually studied* for effective treatment.

GROUP IV. DRUG DISEASES

These are less frequent than everyone supposed prior to the war. The military officials prepared for ten times as many "dope fiends" as were found in the army. Yet there are still quite a few, and for these treatment is a necessity. Successful treatment of morphine addiction requires first of all that the patient be placed in an institution. This may be a general hospital, but if so a special nurse must be secured. The various methods of withdrawal, with or without temporary substitutions, all have their advocates. Diluting the toxins produced by withdrawal by large intravenous injections of normal salt solution has been recommended and the writer has used this method. One important point to keep in mind is that the treatment does not end when the patient has become comfortable again after withdrawal, but must continue, in the way of careful watching and regulation of habits, for at least a year.

GROUP V. GROSS BRAIN DISEASE

The treatment of these neurological lesions can be quickly divided into two types:

For the operable (tumor, abscess, cyst, etc.) *Surgery*.

For the inoperable (some tumors, embolism, hemorrhage, etc.) *Medicine*.

The medicine may be in the form of massage, electricity, heat, passive manipulation, light exercise, re-educational training, etc., as symptomatic relief, or it may be sodium iodide in increasing doses, often combined with other drugs indicated, such

as digitalis, morphine, cascara, nitroglycerin, sodium bromide, glycerophosphates, etc.

GROUP VI. DELIRIUMS

This group is the one seen by the general practitioner most frequently, as it occurs with great frequency in most of the acute infections, (including influenza.) There are several varieties of delirium, and in fact the word itself is very vague and misunderstood by many. I refer to acute delirium, as contrasted with chronic delirium as schizophrenia is sometimes called. Acute delirium, let us say, means here the transitory mental derangement which occurs with acute bodily disease and which disappears when the fever falls to normal, or soon afterwards.

This distinction is quite necessary as there are certain forms which last for a long time after the fever has left the patient, which are probably similar to the deliriums that accompany the fever, but which can hardly be called acute. Their treatment is the treatment of the *chronic* deliriums, which we will take up later.

In acute delirium we are primarily interested in treating the *cause*. This is, of course, the bodily disease which the delirium accompanies. In the case of influenza, with the vague therapeutic indications, this is a rather difficult problem. I shall not attempt to review or summarize here the various modes of therapy found most satisfactory by the clinicians and internists, military and civil, in the epidemic of last winter. I shall only point out certain features which have a particularly beneficial effect on the *mental* complication, which is the delirium.

One of these is cool sponging. We do not know precisely the cause of delirium, but the writer believes that it is the result of brain irritation by some secondary katabolic products released as a result of the hyperpyrexia. Consequently (and this holds good whether my theory is correct or not) lowering the fever lessens the flood of toxic by products, and lessens the brain irritation produced by them, and lessens the delirium.

Morphine is occasionally of great service. I do not know why so many authorities advise against it, unless it be the fear of its abuse. As a matter of fact in the cases of restless active delirium in which an already very sick patient is by reason of his delirium extremely active, and constantly does insule to an already poisoned heart by jumping up, thrashing about, and similar exertion, morphine is almost life saving in its effect, particularly where hydrotherapy, etc., is not available. The patient becomes quiet and sleeps, sponging and rest reduce the temperature, the heart is relieved of the added burden of the patient's restlessness, and the patient awakes later with a lowered temperature and sometimes with an abatement of the delirium. Of course morphine can be abused. There is no indication for it in quiet forms of delirium, in which there is merely a flight of hallucinatory and illusory fancies. In general, the indication for not giving it can be had from the average amount of common sense. My professor of surgery (Harvey Cushing) once said that surgery was the mechanical application to the human body of *common sense*. The medicinal application of the same might qualify as *internal medicine*.

Lumbar puncture, or (rachiocentesis,) is often of great value in acutely maniacal deliriums. The drainage of the spinal fluid seems to relieve a pressure in the cerebral spaces which acts very prettily in some cases. If the fluid is under pressure, 20 cc. or even more may be removed, and under any circumstances it is quite safe to remove from 5 to 10 or even 15 cc.

There is one possible theoretical danger which has recently been pointed out, and that is the induction of a meningitis not by infection but by extension through the brain. I have never seen this occur, and probably it is very rare, but the theoretical proof is quite valid.

One other point about treatment of delirium should be mentioned. This is the fact that since the patient is deluded his conduct cannot be prophesied. These patients often imagine and experience dire

things, such as impending murder, transportation to heaven or hell, torture by demons, deception by friends, etc. They may react to these delusions and hallucinations, and consequently *suicide*, *homicide* and *escape* should be carefully guarded against. Sudden attacks on self or nurse are quite frequent. One of my patients who had seemed normal for some days suddenly sprung from her bed and despite the efforts of a good nurse went directly through a window onto the roof below, but was rescued by another patient before she hurt herself. Every psychiatrist has experienced a personal attack at the hands of mentally sick patients, and I recall in my own case a very vivid instance where the patient was delirious with influenza. He became so bellicose that it was very difficult to feed or attend to him. Furthermore, it was very common during the influenza epidemic of last winter for patients who were supposedly nearly well to escape from their rooms in their night clothes and rush through the neighborhood, occasionally pounding on doors or screaming in fear of death or pursuing demons.

Other than morphine, there are many drugs which may be used, and with benefit. The barbiturates (Barbital or Veronal, Medinal, etc.,) and paraldehyde and sodium bromide are my own preferences.

For the delirium which continues shortly after the fever falls, tub-bathing in water held at 96 degrees F. is often very beneficial. The bath may be quite long but the water should not be permitted to cool.

GROUP VII. MENTAL DISEASES OF AGE

Of course for these there is no curative treatment, no specific. The various drugs used for improving general physical health may be given, and hydrotherapy, thermotherapy, massage, etc., may be of some avail. The nocturnal restlessness is usually one of the most distressing symptoms. Bromides, paraldehyde, medinal, and even codeine and morphine may be used, but usually without a great deal of effect. These cases are usually of brief duration, and mild degree, but may be both severe

and prolonged. For the latter institutional commitment is strongly advisable; for the others home care or residence in a hospital or home for the aged is often preferable.

GROUP VIII. SCHIZOPHRENIA

(Dementia præcox, chronic delirium, the disease of queerness.)

These cases are exceedingly numerous after epidemics of influenza. They were more numerous in a group we studied in Boston than any other two forms of mental trouble put together. There are no doubt hundreds of the same disease represented in Kansas which have cropped out since the epidemic of last winter. Treating these cases is an extremely difficult and discouraging task. First of all it may be said that to treat them at home is well nigh impossible. One of the first essentials of treatment is *removal from home environment*.

I strongly recommend against the company of mother, wife, husband, or children in these cases. It is wise to have them taken entirely away from home folks and faces, and *not* to have these same folk as visitors. They should have *social intercourse with strangers* such as new nurses, other patients, etc. They usually profit by being given to understand that they are in the care of a doctor, as most of them have some degree of insight into their condition.

In addition one should use a number of general therapeutic agencies such as are afforded by a thoroughly equipped private or state hospital. These include: *Hydrotherapy*, or prolonged baths, six hours a day; *Occupational Therapy*, in which they are trained to do manual work of various sorts of a kind previously unknown to them, by workers trained in instructing these folk; *Recreation Therapy*, of a sort suited to the needs of the patient. A stupid, mute patient can not very well play pitch or dominoes, but he might be quite successful in a croquet match.

Medicinal treatment for these cases is still a much disputed question. The writer is willing to believe that two forms of med-

ication are at least sometimes beneficial. I use pituitary extract, injected intramuscularly, on the basis of the successful work of Dr. J. H. Cooper, of the Topeka State Hospital, and his theory of this disease arising as a result or mental expression of disorder of the hypophysis. I also give intravenous injections of saline solution, in rather large quantities. I know of no very good theorization for improvement following this, but I have certainly seen it occur, and can approve it empirically. Possibly it acts merely as a diluent of the toxins which some believe to be the provocative cause.

In short, then, patients of this group must be cared for in institutions devoted to their care and treatment, for the best good of the patient and his family. They are wont to have disastrous outbreaks at times which have often resulted in family tragedies. These, and the disadvantages of attempts at home treatment should be avoided.

GROUP IX. PARANOID PSYCHOSES

By most authorities these are yet grouped in the preceding group in part, and scattered in general throughout the whole system. They form a peculiar group, characterized by abnormal suspiciousness of the motives of the rest of the world. Of this group there are at least four subdivisions, Paranoia, Paraphrenia, Schizophrenic paranoid states (usually called paranoid dementia præcox) and atypical paranoid states. One should remember that paranoid symptoms may occur in any form of mental disease from brain syphilis to hysteria, but these four diseases are characterized by them.

Treatment of these cases is usually confined to custody. They should be given the advantage of psychotherapy, because this may accomplish some good in some cases and should be given the benefit of the doubt. Hydrotherapy, occupational therapy, etc., does them no harm and is too often neglected.

GROUP X. MANIA AND MELANCHOLIA

These two pictures so utterly different, are of course really part of the same dis-

ease, and not infrequently occur in the same patient, sometimes separated by a long interval of time, sometimes in immediate succession, and sometimes even simultaneously.

The treatment is quite different, however, for the two phases. *Mania* must almost always be treated in an institution. There the patient may be given the advantages of hydrotherapy, massage, electric and heat treatment, etc., usually not available outside. Moreover, protection of the patient and of the patient's environment is very necessary, and is usually more feasible in a hospital than elsewhere. These patients, like many of those in the preceding and following group, often require tube feeding, which requires much skill and practice for safe and successful accomplishment. Even in the best hands, cases are sometimes drowned, due to regurgitation, struggles, or even misplaced tubes.

Melancholia, on the other hand, may sometimes be successfully treated at home, although in more severe cases institutional care is preferable. The treatment is based on the principle of reducing external stimuli to the minimum, and increasing in every way factors contributing to the patients' comfort and physical well being. The patients' strength must be maintained, the greatest care must be taken to prevent suicide, and all exertion, fatigue, causes for worry, excitement (including travel) etc., must be prevented. During convalescence there are many forms of treatment which help much, including hydrotherapy, suggestion, (psychotherapy), massage, occupational and recreational diversion, light exercise, etc. These have to be regulated with the greatest possible finesse to each particular patient, and can therefore be only very generally indicated here.

GROUP XI. PSYCHONEUROSES

The diseases of this group are the hysterias, neuroses, psychasthenias, etc., which really make up the greatest group (numerically) of nervous patients. It is a question whether or not the cases of

"nervous exhaustion" about which some psychiatrists are wont to pooh-pooh, but which of late have been arousing considerable discussion, and which are familiar to most general practitioners, belong in this group or not. At any rate they may be treated by the same methods.

All of these disease types are now recognized as (in general) the result of suggestion, and theoretically curable in the same way, by suggestion. They are often the (conscious or unconscious) reaction to the unpleasant. Removal of the cause, however, does *not* in these cases always produce a cure. It is usually necessary to counteract the cause, or to set up a counter stream in the mind currents to dispell the symptoms manifested.

This is brought about in numerous ways. Rest-cures, bathing retreats, etc., were once the great vogue. The resultant cures were generally the combined result of physical improvement and unconscious suggestion. Many of these cases take to the various modern religious fads, including "Christian (?) Science (?) " and certainly do improve and often recover. The fads of "Osteopathy" and "Chiropractic" also actually cure some of them. These same improvements and cures could and can be secured, and are secured, in a multitude of other ways, including Freudian psychoanalysis and sanitarium treatment, and hypnotism, and rest cures.

Every physician who succeeds in treating these cases arrives at his own technique and applies the same, with individual modifications, to every case. Thousands and thousands of these cases were completely cured in the war by scores of different methods. *All of these methods* have the same germinal root, namely *suggestion*, however clothed or dispensed.

There would then be no benefit in the writer presenting his own technique, or detailing special methods. Some cases respond to any method, others resist every method. The more methods tried, the less the chance for cure. Most physicians dislike to treat these cases, but they are very apt to greatly augment the difficulties of

the case by making a half-hearted attempt at it for a while. One of the rules of the successful military treatment methods was that treatment should be persisted in (after positive diagnosis) until a cure resulted, *at the first sitting*. (It sometimes took one minute, and sometimes eighteen hours.) Of course this is applicable in hysteria, and fairly applicable in any other form of psychoneurotic mental affliction.)

GROUP XII. PSYCHOPATHY

The treatment of the "constitutionally inferior" and "constitutional psychopathic inferiority" and other members of this group is summed up as *institutional*.

The unfortunate thing about this is that we have no institutions for them. They are not sick enough for a hospital, nor bad enough (usually) for the penitentiary (even if that were justifiable "treatment") nor "crazy" enough for the state hospitals for insane. They are usually not rich enough to go to private sanitariums, nor are they ever "feeble-minded" enough to go to the state institution for training defectives.

Kansas needs, and needs sorely, an institution for these cases. So does every other state. Massachusetts is giving some attention to the establishment of one, but at present no state has any at all. Psychiatrists, criminologists, social workers, sociologists, educators, and many others are joining in a chorus pleading for such institutions, but until the Mental Hygiene movement gets under way in the west and until "politics" is replaced by regard for social responsibility in east and west, we can only hope for a successful issue, without much immediate prospect.

SUMMARY

The summary of this paper may be put in the words of the first publicity issued by the State Commission on Mental Hygiene. They are:

1. That many mental diseases are preventable.
2. That many mental diseases are curable.
3. That there are right and wrong methods of treating even the incurable.

These methods, for curable and for incurable, follow in general the diagnostic groups, and are presented in brief and fragmentary outline in this paper. Generically they are to *make a correct diagnosis first*, and then to remove or combat the *cause*, and to alleviate the symptoms.

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Fables for the Kansas Doctor

By RENNIG ADE

Once upon a time there was a Kansas Doctor who had braved the storms of many winters and had given the best years of his life to the sick and distressed. The cares of 55 years had silvered his hair and slightly bent the rugged form. The ripe experience gained in an active general practice combined with a natural aptitude for study and research had made him an honor and credit to the profession and a valuable member to the community. The sudden appearance of tuberculosis in the only child, a girl of 14, made it incumbent upon him to seek another climate, and the finances did not permit relinquishing his practice. The only logical thing to be done was to become registered in the state in which it was necessary to take the daughter. He therefore made preparations for the ordeal. He sent his photograph along with his birth certificate, vaccination certificate, kinder-garten record, and Sunday-school attendance card. He sent affidavits from the Governor, President of the State Medical Society, Justice of the Peace, and Secretary of the Welfare Board. He was vouched for, recommended, praised, endorsed, and flattered until he began to have considerable respect for himself and felt very sorry for the community he was leaving.

The next few months were spent in reviewing his chemistry and a number of other studies in which he had of necessity become rather stale. He was somewhat surprised to find the members of the examining board to be men who were not especially known for their scientific attainments. Instead their appointment to the board was the reward for zeal manifested along political lines, and in one state two veterinarians and an auctioneer (who was nicknamed "Doc") were appointed by mistake and served satisfactorily on the board for three years.

In justice to the two professions however it must be explained their questions were furnished by a doctor's office girl who clipped them from the "Medical

World." The successful applicants were determined by putting the names in a hat and drawing out whatever per cent had been agreed upon. This saved looking over a lot of papers and gave everybody a square deal. This was accidentally found out when the janitor's little boy was issued two certificates to practice medicine, he having slipped his name in the hat while the board of examiners were down in the basement. The questions given by the board were sufficiently perplexing to guarantee the technical knowledge of each examiner and were not supposed to be answered correctly by any sane practitioner. Combining (NH₄)₃PO₄ 11Mo 03 6H₂O with KHC₄H₄O₆ is a trivial task for an ordinary member of an examining board, but questions of this kind proved a laborious proposition for our doctor.

For three days the old gray head pored over his examinations, the shoulders drooping lower each day. At last the nightmare ended, he was taken home and put to bed singing and jibbering. He imagined he was a Hydatid cyst about to be punctured by a party of Oxyuris Vermiculares who were out seeing the town. Next he was demonstrating a Whitehead hemorrhoid operation to the board of examiners, made too much traction and pulled the epiglottis out. Then he spent two days trying to combine HNO₃, 606, and Dakin's solution into a food suitable for a baby 6 months old with two wisdom teeth who complained of bearing-down pains. When his brother arrived from Kansas he insisted upon going back with him and four weeks later was able to make the journey. The daughter was placed in a sanitarium, the mother remaining with her. The doctor went back to the old home town in Kansas to resume practice where the sky is the bluest, the sun is the hottest, and the people the best of any place in the world.

Moral—If you want to change your location, learn the plumbing trade.

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Excerpts by The Prodigal

MUSICOTHERAPY

Music is a recognized therapeutic curative agent. It is not in common use by the medical profession. It is used in the insane asylums and has been for many years. It was used in these institutions at first because the noise drowned more unpleasant sounds and attracted the attention of the daffy ones; probably? Having the same effect as the Tom Tom. The scientific use of music in mental diseases

was not understood. It was used on the principle of the laity in their advice to the sick—to "Take something." Music is one of nature's products. It is a creative expression of harmony. The mechanism (key board) of the ear is the receiver. The key board of the piano is patterned after the acoustic receiving apparatus of audition. Sound waves are conveyed to and hit these keys and cause the different, but harmonious sounds. Each auditory key, like that of the piano, makes but one sound. One sound only and always the same kind of sound, when normal. There are five or six special senses; namely, hearing, seeing, smelling, tasting and feeling. Intuition? Satisfying these senses puts the physical man at ease. When these senses are normal, the man like the tuned instrument is ready to function harmoniously. These five or six senses are interdependent one upon the other. They are helpers each to the other, synergists. For example, the eye helps the ear in hearing and vice versa. The nose helps the taste for food. The odor of the food makes it taste better, helps the appetite. Again it is by the special senses that man is able to differentiate between the pleasant and the unpleasant things. Between the harmless and the injurious or harmful ones. All the senses have to be satisfied and all the desires gratified, both natural and acquired, to put the human at ease. Man has requisitioned everything in the heavens above and in the earth beneath to satisfy the senses. When all of the special senses are in harmony, each one adapted to the other, there is music in the soul.

In one sense instrumental and vocal music is a by-product, an asset to the capital—Life. Its use adds to the sum total of human happiness. Like the meat packers by-products, it is life's profit. The use of music is the price of culture. It is an evidence of evolution, of progression toward the higher life. It tends to sooth the inner longing for something better in life. It is proof that man has something in him other than brute. Music like sympathy is the aroma of the flowering fruit of the soul. It harmonizes, puts at ease and to rest, discordant, vibrating, tingling terminal nerve filaments of all the senses. It is the hand maiden of all the senses. And in its use for the sick a specialist is not necessary. The family doctor is the one to dose it out. His musical talent is on a par with that of his patient. He harmonizes with his patient or he would not be treating him. The doctor can determine

the kind, or character of the music to use by the church, or no church, the man belongs to, the same as a man's religion may be known by the automobile he owns. For example, a Baptist drives a Mercer, a Catholic a Pope and a Christian Scientist a Ford and thinks he is riding in an automobile; and all other owners are Pundits.

In making a selection of songs for the weak and mentally depressed it will be safe for the doctor to omit, "Hark from the Tomb that Doleful Sound," or "In a Lonely Graveyard." Again—the average doctor can't sing. He should not try. If he has a melodious Caruso voice, is handsome, real pretty, he should not dispense drugs. He should practice on his shape and voice. The phonograph is the doctor's salvation. Every family has one or can borrow from a neighbor. Hence the doctor should not risk the loss of a patient by trying to sing to him.

The music should fit the sick one and not try to fit the sick one to the music. It is no time to cultivate the uncultivated ear to classical music that cannot be understood. Such teaching wastes time and is a breaking away from old and set impressions and is liable to jar the ear and cause pain—producing the opposite effect from the desired therapeutic effect. The patient's taste should be consulted and the old tunes of childhood and early life may be ventured. If the patient is temporarily daffy empiricism is the way out. The dose should be given under the supervision of the attending physician. It must be palatable and leave a taste for more. A yearning for the doctor to come and repeat the dose; but not so long between doses as to defer hope too long "which maketh the heart sad." It is well to remember, also, that there are persons born without a musical ear. Some or all of the musical acoustic keys are missing. Other keys may be rudimentary or deformed and cannot function. Nature has made a bauble, seemingly, as in deaf mutism, or spina-bifida, or lacking an ear. Where there is this lack or deficiency in development of the musical acoustic receiver, training does no good. It is said of such a one, he has no ear for music. The percentage of this class of persons is small. But there are enough of such persons to bar the axiom in musical therapeutics. To some of these defectives music is distressing. In that class of patients omit music. The doctor may have to learn the patients distaste for music, not from what the patient says, but from the effect the music has upon

him. For some persons are so sensitive of their lack of appreciation of music that they try to hide the hidden deformity, the same as they would a misshapen member of the outer body.

These vaudeville remarks are made in earnest and in jest. In earnest because believed. In jest for the etching effect or sticker. And second—they are made for those whose musical talent and knowledge are in an X-ray class with the Prodigal.

HAS-BEEN VERSUS QUITTER

A doctor should not regret being a has-been, if he has done his bit. Being a has-been and not knowing it is a misfortune to the ego. When the shade of professional life begins to obscure the vision of medical progress or when the whirligig of time rotates beyond the center, lessening its rotary motion, as evidenced by loss of interest in his work, he has crossed the border and begun his journey in has-beenland. The doctor who recognizes the scenery and the landscape and the paved boulevards, in fact takes it all in at one kaleidoscopic view and notes the procession and the music and drops in line and steps off gracefully as he should do, has no regrets or pity coming to him. In fact he is in luck. True he is up against the real thing—he has been all his professional life. He has familiarized himself with the inevitable and is prepared for the change. He meets his guest half way. There is no surprise. It is the same as meeting an old expected friend whose acquaintance has been ripening by the introduction of time until there is a pleasure, a oneness in meeting. The doctor can now sit down in the shade of the evergreen tree, by the roadside and fan himself and watch the processions pass by. Having marched in the medical procession himself, he knows what it means to be a marcher. Nature has satiated his desire to march, but has increased his pleasure in watching the procession go by in double quick step of greater efficiency. He contrasts the old with the new; the defects and progress in medical evolution. That perfection has not been reached, but the goal is nearer. The has-been age is the let go time in life. It is the rest time, the time to think, to study, to find out what he is here for and to cultivate the fallow land of the soul.

The Quitter—He is a misfit, a mistake. He is neither food nor garbage. There is no place for him among men or beasts. He cannot be used for fertilizer. He has to be made over, but it cannot be done in time—there is not enough time left. He is a

pessimist, a kicker, a faultfinder. He has been outdistanced in the professional race. He has been tested and found wanting. He never had it in him. It was not the test that broke him down—the test showed that it was never there.

This diatribe is applicable to a quitter in any and all walks of life, but especially to the medical quitter, who forsakes all interest in scientific medicine and goes off on a tangent of nebulism. A kind of self luminous mass of attenuated matter outside the medical solar center, to fool the sick.

Creative intelligence only can renovate such an one and forge the missing link. Peace be to the Quitter's ashes—Selah.

—R—

Keep the Home Fires Burning

Before the war the United States was dependent on foreign sources, chiefly German, for supplies of chemicals, dye stuffs, drugs, optical glass, chemical porcelain, surgical instruments, and scientific instruments of several sorts. Until importations stopped, we did not fully realize our helplessness and weakness. Now we know and are resolved to make, at home, all the things which, before August, 1914, we had to have from Germany or go without. As Secretary of Commerce Redfield says, "We should never again find ourselves in the position that developed in the early part of the war, where needing many things, we found ourselves making almost none."

The making of medicinal chemicals is an essential industry both in peace and war. The United States has the materials and the scientific knowledge, the equipment and the capacity to compete with the best medicinal products of foreign manufacture.

The U. S. Federal Trade Commission and the Chemical Foundation are making it possible for American manufacturing chemists to produce, in this country, those products which, until the war, were controlled in Germany.

Among these products are barbital, introduced as veronal, procaine, introduced as novocaine, and cinchophen, introduced as atophan.

The Abbott Laboratories of Chicago has done splendid pioneer work in producing these and other products used by the medical profession and hospitals. If made worth while, they can always find the fuel to keep the home fires burning.

Booklet giving indications for and dosage of cinchophen will be sent on request to the Abbott Laboratories, Chicago.

THE JOURNAL

of the

Kansas Medical Society

W. E. McVEY, M.D. - - Editor

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What Do the People Owe the Medical School?

Some of our legislators excuse their reluctance to make a sufficient appropriation for the Medical School by charging the medical profession of Kansas with apparent indifference to its existence.

Why should the medical profession be less indifferent than other people? From a business man's point of view there is no reason for our showing any great enthusiasm over an institution constructed and conducted primarily and secondarily for the benefit of—not the medical profession—but the people of the state. It is of no interest or benefit to the medical profession except as it serves the people of the state, and serves them in the same way and to the same ends that we serve them.

For years past the doctors have persistently forced upon the people repeated vaccination against typhoid fever until they have finally and completely deprived themselves of that once most lucrative and dependable source of income.

If the campaign against venereal diseases continues to be prosecuted on the same vigorous lines that have marked its beginning, in a few short years another

most prolific source of revenue will have entirely disappeared. And yet the doctors are in front of, in the midst of and behind this movement.

A good many years ago a school of medicine was started at the University. It did not amount to much and it did not grow very rapidly, but it was kept alive. Then an old retired physician who wished to perpetuate his name in the medical history of the state donated lands and money for the building of a medical school at Rosedale. Another retired physician, one time Governor of the state, left his estate to the University with the expressed wish that it be used for the medical school. During all these years, however, the state has made niggardly provisions for the maintenance of the school. Even the estate of Dr. Robinson is not permitted to be used for the purpose he desired. The buildings are largely unsuitable for the present requirements, are wholly inadequate for the demands upon them and are very deficient in equipment, but the representatives of the people do not provide for their improvement.

During the past four years Nebraska has expended \$500,000 in equipment for its medical school. Quite recently Oklahoma has erected a \$200,000 hospital for its medical school. Kansas provides for the maintenance of its school on a most economic basis and for the very modest salaries of a part of its faculty. Only thirty-eight per cent of its faculty receive any salary. Sixty-two per cent of the members of the faculty of our medical school donate their services—not only their services as teachers, but their services in the hospital and in the free dispensary.

During the year ending June, 1918, the hospital cared for 1,187 patients, poor sick people of the state, who remained in the hospital an average of 14.5 days each. The hospital has only sixty beds including those in the corridor that are used for children and there is always a waiting list. Patients are sometimes compelled to wait two weeks or more before they can be accommodated. This is the state's hos-

pital where the best medical and surgical attention is given the people without charge. During the same period 2,973 poor sick people were given free medical and surgical attention in the Dispensary. To these 2,973 people 12,367 treatments were given. If we calculate the hospital service at the lowest ward rates, and the medical services according to the lowest fees charged—leaving out entirely the usual fees for the very many surgical operations included in this service—the value of the services rendered the people by the medical school is \$77,527.

But all this service is secondary to the primary purpose of the medical school—a by-product one may call it. The primary purpose is to prepare men for the practice of medicine and to prepare them thoroughly and scientifically. For this purpose, including salaries, maintenance of the hospital, the dispensary and scientific departments the state has appropriated \$53,759. There are in the medical school, in all classes, 136 students. The state therefore pays \$395.28 each for the year's training of these students, but the state receives in actual value of services rendered \$77,527, a net profit of \$23,768 or \$174.76 per student. Soon the state will furnish a larger hospital, more equipment and better facilities, and the amount of these services to the poor people of the state will be trebled.

When the last legislature conditioned its appropriation of \$200,000 for a new hospital upon the raising of a sufficient sum by Wyandotte County to purchase additional ground, it was possibly a recognition of the principle that the county in which the hospital is located would benefit more largely and more directly than other parts of the state, but it also unintentionally perhaps, afforded an opportunity to show to what extent the services rendered by the school and hospital are appreciated by those to whom these services are most readily available. It is a safe prediction that among the most active in the campaign for these funds, if not also the most liberal contributors, will be found

the members of the medical profession.

Members of the medical profession have donated more than the amount invested in the medical school plant. Two-thirds of the doctors, who are teaching the students and caring for the sick in the hospital and dispensary, donate their services to the state. At the lowest estimate of their actual value the services rendered the people by the medical school—outside of its educational function—amount to nearly fifty per cent more than the amount expended by the state.

A financier would certainly question the business sense of one who gives thus freely of his time, his energy and his capital to promote a competitive industry. No lawyer, or banker or merchant could tell why the doctors forced upon an unwilling people the preventive measures against small pox and against typhoid fever; nor why they have projected with still greater energy this campaign against venereal diseases. None but the thoroughly competent conscientious doctor, who is loyal to his people and his profession, can answer that question.

For although the art of healing the sick has of necessity become a business, there is still some of the sentiment of the artist in those who practice it; there is some of the spirit of the explorer, but without the stimulus of a possible great name which succeeds to a great achievement. The greatest achievements of the physician are of such an intimate and personal kind that they must ever remain unhonored and unsung.

—————R—————

Be careful when you make your will. Be sure that its terms are specific and definite. When you think you have left your estate to your son the lawyers may find that you have really left it to your divorced second wife's cousin's nephew. You may bequeath a hundred thousand to found a hospital for crippled children and die in fond belief that your memory will be perpetuated in a good work. But if there are means of communication with the other world, you may find that the in-

terest on the invested income from your hundred thousand will be used only to buy crutches.

One of the pioneers of Kansas, one of the gentlemen who helped to make a good deal of Kansas history, who was greatly interested in the educational institutions of the state, who was himself a graduate in medicine, wished to aid in the development of a great medical school in the state he had helped to build. He left his estate, worth something like a hundred and fifty thousand dollars, for that purpose, as he thought. Years after his death, after many and weighty legal opinions had been secured, the medical school is permitted to receive the interest on the income of this estate.

The conditions were not quite such as might be inferred from the foregoing. The State is apparently willing to receive bequests, but insists that there shall be no strings attached. However it has usually been its policy to dispose of such bequests as the donor desired. Why in this instance his wishes were ignored can, perhaps, be explained by the lawyers, to their own satisfaction at least.

Among the things that impress one in reading the many medical and surgical reports of the world war, is that so much of the experience gained before the war was apparently lost, so many of the things already learned had to be learned over again. Many of the newer plans of treatment adopted in the beginning were superseded by methods already proven in civilian practice. After much of the current literature has been reviewed one concludes that surprisingly little of actual value has been added to medicine by the experiences of the war.

Without presuming to question the efficiency of psychotherapy, without doubting the acute perception of those who practice psychoanalysis, one must feel some mental inferiority who reads the reports of such analyses. Those ancient interpreters of dreams were amateurs when compared

with our modern seers. The childish credulity, however, with which these analyses are presumably accepted by the unfortunate derelicts suggests a degree of imbecility beyond the benefits of even psychotherapy.

—————R—————

F. W. Shaw (Am. Review of Tuber.) reports some experiments upon rabbits which show that pulmonary collapse favors the formation of tubercles. After one lung had been collapsed rabbits were injected with a suspension of human tubercle bacilli. In each instance tubercles were found in the collapsed lung, and in no other organs of the body, and this occurred whether the injection were made into the trachea or into the ear.

—————R—————

An Appeal for Human Embryological Material

WILLIAM M. GRAVES, St. Louis.

In 1906 I observed certain malformations of the human shoulder-blade, and in contributions to current literature I have given them the collective name, "the scaphoid type of scapula," and pointed out some of its hereditary, clinical and anatomical significance.

Probably the most important observation connected with this type of scapula in man is its age of incidence; that is to say, it occurs with great frequency among the young and with relative infrequency among the old. There appear to be two possible explanations of this fact: Either (a) one form of shoulder-blade changes into the other during development and growth, or (b) many of the possessors of the scaphoid type of scapula are the poorly adaptable, the peculiarly vulnerable, the unduly disease susceptible—the inherently weakened of the race.

I have attempted to answer these questions by seeking evidence in various directions and one of the most important of these has been a study of intra-uterine development of shoulder-blades. My investigations in this direction have been limited by the material at my disposal, which has been inadequate for a definite solution of this phase of the problem. I am, therefore, appealing to physicians for fetuses in any and all stages of human development.

It is desired that the material, as soon as possible after delivery, be immersed in 10 per cent formalin in a sealed container,

and be forwarded to my address, charges collect. Due acknowledgment will be made to those forwarding material. Address 727 Metropolitan Building, St. Louis, Mo.

—R—

The Mental Hygiene Movement

What would you do if a case of mental disorder suddenly developed in your own household?

Supposing the patient were delirious, frenzied, or uncontrollable, what would you think of the present necessity of locking him up in the county jail to await trial? If the treatment he received subsequently, which might be the best available, was wholly unsatisfactory, owing to inadequate provisions, what would you do about it?

Would it ever have occurred to you that the tragedy might have been prevented?

About ten years ago a resident of New Haven, Conn., by the name of Clifford Beers, developed such a mental disorder, and his family (like thousands of others each year) were for the first time up against the questions hypothetically proposed above.

Mr. Beers became seriously disturbed and was (after divers sad experiences) finally committed as insane in a state hospital. In this institution he was apparently more mistreated than treated, and suffered greatly. The sufferings of his family with grief for a supposedly "incurably insane" son and brother can be imagined.

This "incurably insane" man recovered! He left the hospital for the insane convinced that the public had too long ignored the fate of the mentally sick. He became imbued with the idea that others with mental disease could get well, like himself, if properly treated; that the public itself was largely to blame for the mistreatment of mental cases, the inadequacy of provision for them, and the retardation of the science of prevention and treatment, by its callous indifference to the whole subject. He talked with leading psychiatrists of the country and became still further inspired by the information that many mental diseases are preventable!

With tremendous inspiration and energy he set about to organize an association for spreading information about these facts. He wrote a remarkable book, which every one ought to read, entitled "A Mind That Found Itself." He organized a local organization; this became a state organization, and finally a national organization was founded; the funds were solicited, the employes secured, the machinery started.

State organizations affiliated with the national organization followed, and soon all over the United States there were state organizations, leagued with the National Committee of Mental Hygiene, for the spread of information about mental disease, its prevention, its cure, and the securing of proper legislation, proper attention, proper provision for matters pertaining to diseases of the mind.

The work of these associations has become very broad and very extensive. Surveys of the states were instituted to ascertain the numbers of uncared for cases, the adequacy of the provision, the misplaced cases, the feeble-minded children in prisons and crazy men in penitentiaries and demented women in poor-houses. (Do not delude yourself into supposing that such is not the case in your state.) Help for the returned soldier with shattered nerves is proffered, the school children with difficulties are examined and reclassified or prescribed for, the court cases are supervised by mental experts so that mental examination may precede legal examination, and many other activities are afoot. Some of these are conducted by the national, some by the state organizations.

The situation in Kansas is detailed below.

To summarize, then, the Mental Hygiene movement arose from the efforts of one man, now supported by thousands of progressive people all over the United States. Its aim is to reduce, by organized endeavor, the alarming amount of mental disorder and disease, or as it is officially put: "To work for the conservation of mental health; to promote the study of mental disorders and mental defects in all their forms and relations; to obtain and disseminate reliable data concerning them; to help raise the standards of care and treatment; to help co-ordinate existing agencies, federal, state and local; and to organize in every state in the Union an affiliated Society for Mental Hygiene."

THE KANSAS SITUATION

Kansas has no state society or association for Mental Hygiene, or anything corresponding to it.

About three-fourths of the states of the Union already have such organizations.

Facing this remarkable retardation (for so progressive a state) Governor Allen appointed, soon after his accession to office, a State Commission on Mental Hygiene. It was the avowed purpose of this commission to study the Kansas problem, and to take steps to correct the present lack. Every

one recognizes the need for something like the Mental Hygiene movement, and it only remains for the machinery to be set going to inaugurate in Kansas an association such as now exists in most of the other states.

The Governor has exerted a maximum effort in bringing this about. The Commission he has appointed immediately took up the assigned duty. The secretary went to New York, conferred with the officers of the national organization, and made arrangements for a personal visit in Topeka for one of them in August and several in November.

Members of this Commission met in Topeka October 3 of this year, 1919, for the completion of these plans. In November a second meeting will be held, at which time every citizen of Kansas who is interested in the subject of Mental Hygiene is invited to attend. At this time, it is proposed, a state association might be formed. This meeting will be held in Memorial Hall, Topeka, November 20.

There will be speakers of national reputation, and information of unparalleled interest, to you. And you are invited if you are a citizen of Kansas.

—————R—————

BOOKS

"What We Know About Cancer"

A hand-book for the medical profession. Prepared by a committee of the American Society for the Control of Cancer, American Medical Association Press, Chicago, 1918.

The American Society for the Control of Cancer has been in existence and working effectively for a number of years. The sole object of the society, at present at least, is the "dissemination of facts in regard to cancer to the end that its mortality may be reduced by a wider knowledge of the disease."

The effort represented by the present pamphlet has perhaps the most far-reaching possibilities for good of any single attempt to lessen cancer mortality undertaken in this country.

It is no longer necessary to argue the point that delay is the one great factor in cancer mortality. At least four-fifths of cancer deaths could be prevented by early recognition. The conditions necessary for recognition of cancer in ample time for cure are not ideal but distinctly practicable. Public education is one important pathway of improvement, but education of the medical profession itself is of equal if not greater importance. Statistical studies have shown that in the

majority of cases the doctor has had the cancer patient "under observation" over a year before efficient curative treatment is instituted. It is needless to state that during this year the majority of cases have changed from curable to incurable. As the pamphlet itself somewhat mildly puts it, "The conditions call for a far keener appreciation of responsibility for the mortality from cancer than now generally exists in the medical profession."

It is not possible here to abstract this pamphlet which is already so condensed. The general facts concerning cancer are outlined and then each important type and site of cancer is taken up in detail and the forms, symptoms, standard treatment, and results to be expected are outlined for each type.

The chief point we would make here is that if every medical man would study and seriously apply the teaching in this pamphlet, which he can read in an hour, the question of delay in cancer would be solved in so far as it is referable to the medical profession. The ultimate possible good obtainable from the widespread dissemination of this pamphlet is so great that we would urge every possible means to get it into the hands of as many medical men of all classes as possible. It can be had from the American Medical Association, 535 N. Dearborn Street, Chicago, for 10 cents. If you are a trained surgeon, get it. It will interest you. If you are further afield, get it and study and apply it. If you feel misgivings that some of your cases in the past might have been saved had you been more sure and acted more promptly (and who of us does not have such misgivings?), get it. It will help you in future cases.

We would especially beg the assistance of boards of health, both state and municipal, and of medical societies in distributing the pamphlet. It can be bought cheaper in quantities and sent out with your other mail matter with almost no extra cost or trouble. When such a simple means for such far reaching good is in our hands it is a pity to let it lie neglected.

—————R—————

The mind cure is now rampant. The body is becoming a negligible quantity. There is danger of losing sight of it. The regular medical profession is the only archive to preserve the unity of body and soul.

—————R—————

The world war did more for medicine than a century of didactic teaching.

SOCIETY NOTES

BARTON COUNTY SOCIETY

One of the most pleasing functions we have attended for a long time was the reception given the Barton County men of the M. R. C. by the medical society of that county at Great Bend the night of October 16th. Out of about 24 practitioners in the county, 10 enlisted in the M. R. C. and did active service. This is a most creditable showing and we question if many counties of the state did as well.

Members of the profession and their wives gathered from the surrounding towns even as far away as Hutchinson and spent a social evening with music, banqueting and toasts.

Owing to the Hutchinson visitors having to catch an early train the program started at 7 o'clock and was put through with vim and energy. (Which, by the way, is more than can be said of a great many medical banquets.)

Dr. H. C. Enbry, President of the Barton County Society, in welcoming home returned physicians, delivered a well prepared address in a most earnest manner and paid a fine tribute to the men of the M. R. C. Dr. E. E. Morrison then took charge and proved himself a most able toastmaster. The following program was carried out and everyone went home voting the Barton County Society to be a mighty live proposition.

The Citizen Soldier, Dr. J. A. Dillon.
The Army Horse, Dr. N. W. Robinson.
Congeniality in the Training Camp, Dr. T. J. Brown.
Some French Customs, Dr. C. W. Zugg.
"It is Not Good That Man Should be Alone," Dr. Benedict Jury.
Big Game, W. A. Nixon.
The Firing Line, Dr. E. H. Atkin.
The French Sense of Humor, Dr. R. J. Wheeler.
Selected, Dr. M. F. Russell.
Good Night, Dr. Addison Kendall.
Musicians: Mrs. Russell, Violin; Miss Charles, Flute; Miss Dodge, Piano.
Roll of Honor: Dr. M. F. Russell, Dr. W. A. Nixon, Dr. N. W. Robinson, Dr. R. J. Wheeler, Mr. S. S. Maginnis, Dr. C. W. Zugg, Dr. T. J. Brown, Dr. H. W. Jury, Dr. E. M. Adkins.

CENTRAL KANSAS MEDICAL SOCIETY

The Central Kansas Medical Society held its regular meeting at St. Anthony's Hospital, Hays, Kansas, October 21, 1919. The President, Dr. F. S. Hawes, called the

meeting to order. The following members were present: Drs. Jamison, Blake, Meade, Middlekauf, Anders, Hennerich, Bett-hauser, of Hays; Drs. Hawes, Stewart, Cramm and Koerber, of Russell; Dr. O'Donnell, Ellsworth; Dr. Davis, Kanopolis; Dr. McCormick, Plainville; Dr. Stoner, Ellis; Dr. Butler, Winona; Dr. Herrick, Wakeeney; Dr. Turgeon, Wilson and Dr. C. B. Francisco, Kansas City, Mo.

The following program was read:

X-Ray Pictures and Clinical Histories of Same, Drs. Blake and Jamison.

Renal and Vesical Calculi, Dr. A. O'Donnell, Ellsworth.

Treatment of Pneumonia—Per the Army, Dr. F. S. Hawes, Russell.

The Treatment of Fractures of the Femur and Their Management—Per the Army, Dr. C. B. Francisco, Kansas City, Mo.

After the banquet at the hotel Dr. Francisco read his paper and demonstrated the apparatus used in the several forms of femur fractures which as appreciated by all present.

After the program was completed all the members were invited to the home of Dr. O. B. Hennerich where they were royally entertained by the Doctor and his wife.

Next meeting to be held at Russell, December 10, 1919.

SUMNER COUNTY MEDICAL SOCIETY

The Sumner County Medical Society met in the Commercial Club Rooms at Wellington, Kansas on Thursday evening, October 9, 1919.

The following program was prepared:

A Clinic, by Dr. A. R. Hatcher.

A Paper, by Dr. J. C. Wall, entitled "A Plea for Early Diagnosis of Cancer of Cervix."

A Paper on "Pneumonia," by Dr. H. A. Vincent.

The officers of the Society are:

M. W. Axtell, President.

W. M. Martin, Vice President.

T. H. Jamieson, Secretary.

Obituary

Dr. Daniel P. Cook was borne at Camden, N. Y., September 8, 1851, and passed to his reward at his home in Clay Center, October 2, 1919, at the age of 68 years and 24 days. He moved with his parents from New York to Kalamazoo, Mich., where he grew to manhood, graduating in 1880 from the school of medicine in the University of Michigan at Ann Arbor, where he received his M. D. degree. Dr.

Cook came to Kansas in 1882 and has been an active physician in Clay Center for 35 years. He was married December 25, 1884, to Miss Ella Webber, and his loving wife; two sons, Robert Roy of Topeka and Morrill I. of Enid, Okla.; one daughter, Florence, of Clay Center; and one sister, Mrs. Esther Hope of Kalamazoo, Mich., and one grandchild, Morrill Cook, Jr., are the immediate relatives in the bereaved family.

Dr. Cook was honored with different positions of trust and responsibility. Under Governor Stanley he was appointed a member of the first state board of Medical registration and examination.

Reciprocity for the Old Fellows

By a recent decision of the State Board of Registration and Examination the men who were licensed to practice before the requirement for an examination went into effect will again be given their rights. The regulation which was rescinded and which has been reenacted is as follows:

QUALIFICATION No. 2

That a certificate of registration or license, issued by the proper board of any state, may be accepted as evidence of qualification for reciprocal registration in any other state: *Provided*, The holder of such certificate has been engaged in the reputable practice of medicine in such state at least one year: *Provided, also*, That the holder thereof was, at the time of such registration, the legal possessor of a diploma issued by a medical college in good standing in the state in which reciprocal registration is sought, and that the date of such diploma was prior to the legal requirement of the examination test in such state.

The Samuel D. Gross Prize—Fifteen Hundred Dollars

Essays will be received in competition for the Samuel D. Gross prize until January 1, 1920. The conditions annexed by the testator are that the prize "shall be awarded every five years to the writer of the best original essay, not exceeding one hundred and fifty printed pages, octavo, in length, illustrative of some subject in Surgical Pathology or Surgical Practice, founded upon original investigations, the candidates for the prize to be American citizens."

It is expressly stipulated that the competitor who receives the prize shall publish

his essay in book form, and that he shall deposit one copy of the work in the Samuel D. Gross Library of the Philadelphia Academy of Surgery, and that on the title page it shall be stated that to the essay was awarded the Samuel D. Gross prize of the Philadelphia Academy of Surgery.

The essays, which must be written by a single author in the English language, should be sent to the "Trustees of the Samuel D. Gross Prize of the Philadelphia Academy of Surgery, care of the College of Physicians, 19 South Twenty-second Street, Philadelphia," on or before January 1, 1920.

Each essay must be typewritten, distinguished by a motto, and accompanied by a sealed envelope bearing the same motto, containing the name and address of the writer. No envelope will be opened except that which accompanies the successful essay.

The committee will return the unsuccessful essays if reclaimed by their respective writers, or their agents, within one year.

The committee reserves the right to make no award if the essays submitted are not considered worthy of the prize.

WILLIAM J. TAYLOR, M.D.,

JOHN H. JOPSON, M.D.,

EDWARD B. HODGE, M.D.,

Trustees.

Philadelphia, May 15, 1919.

Auto-Chir Functioning in Roumania

The auto-chir, the mobile hospital purchased by the American Red Cross for the American Expeditionary Forces at a cost of \$400,000, has been sent to Roumania. It was intended for France, but the signing of the armistice ended the need there, and when Queen Maria of Roumania appealed for help from the Red Cross it was decided to send it to the aid of the diseased and impoverished nation.

The hospital was sent by ship from America to Bologna, Italy, thence on its own wheels to Bucharest under the care of Col. George de Turnowsky of the American Army. The entire city turned out to greet it when it pulled up before the palace grounds.

The auto-chir consists of an X-ray truck, an electrogenic group with accessory parts, a heating plant, a rolling machine shop, an electric lighting plant, an operating room with plate glass, cabinets containing every known surgical instrument, ambulance trucks containing beds for twenty patients, four ambulances capable

of accommodating six severely wounded or twelve slightly wounded men, tent hospital trucks, an acetylene truck for lighting up the hospital, store room trucks with large supplies of blankets, cots, sheets, dressings and drugs. There is also a large truck which contains sleeping rooms for doctors, nurses and internes. Eighteen huge trucks resembling American moving vans constitute the complete hospital.

It has moved up near the Roumanian army, where it is functioning with a speed and efficiency that is bewildering the army personnel, practically all of which has turned out to see it.

—R—

Solubility of Intestinal Ipecac Preparations

T. Sollman reports that in the administration of ipecac preparations against intestinal amebas, salol coated pills are not always satisfactory, although with due care it appears quite feasible. He reports that emetin bismuth iodid, which is described in New and Nonofficial Remedies, is only slightly soluble in water and dilute acid, but dissolves quite freely in 1 per cent sodium bicarbonate solution. It is somewhat soluble in the stomach and produces some digestive disturbances. Alcresta ipecac, an absorption product of ipecac and Fuller's earth, though sold with the claim that the alkaloids are "physiologically inert as long as they remain within the stomach, and are rendered active when set free in the alkaline media of the intestine," was found by Sollman not to be decomposed with liberation of alkaloid by solutions having the alkalinity of the intestinal fluid. Ordinarily, it would not be expected that a substance which is quite insoluble in the intestines should still be effective on amebas. The findings of Sollman demand a careful examination of the clinical evidence on which the use of alcresta ipecac is based. (Jour. A. M. A., October 11, 1919, p. 1125.)

—R—

Vocational Education

Vocational rehabilitation, similar to that now in operation for disabled soldiers and sailors, is provided for "persons disabled in industry or otherwise" in the Smith-Bankhead bill which has just passed both houses of congress.

The bill provides one million dollars yearly to enlarge the scope of the original Smith-Hughes act creating the Federal Board for Vocational Education and its recent extension to cover war cripples so as to assure the maimed victims of indus-

trial accidents, also, the opportunity for vocational re-training into skilled occupations suited to their physical powers and restoration to useful, self-sustaining jobs.

Physicians, especially industrial physicians, employers, state workmen's compensation officials and organized labor endorsed the campaign for this protective legislation, which was aggressively led by the American Association for Labor Legislation which is also active in promoting workmen's health insurance as the next big step following the successful development of workmen's compensation laws.

"There are at present," it was pointed out in the congressional debate, "more than one hundred thousand permanently incapacitated workers in the United States, who will be benefited by this legislation, and this large army of casualties of peace is being increased at the rate of 11,500 every year."

Under the bill as passed by congress the individual states must provide at least one dollar for each dollar expended by the federal government on behalf of their own crippled workers. Several states have recently taken favorable action in anticipation of congressional co-operation now assured in the Smith-Bankhead bill.

—R—

Formaldehyde Tablets

During the recent influenza epidemic a variety of tablets or lozenges were advertised which were claimed to owe their asserted value to the fact that they contained formaldehyde and liberated it on contact with the saliva. Tablets containing hexamethylenamine or other formaldehyde compounds can neither cure respiratory infection, nor even confer a protection against such infection. To be effective, formaldehyde would need to be supplied to the entire respiratory tract continuously for some time, or else in concentrations that would be distinctly irritant and damaging to the tissues. Some years ago the Council reported on the inefficiency of formamint, which was said to be an efficient germicide by virtue of the liberation of formaldehyde on contact with the saliva. To call attention to the inefficiency of this form of medication, the Council on Pharmacy and Chemistry now reports that the following were found inadmissible to New and Nonofficial Remedies: Hex-Iodin (Daggett & Miller Company, Inc.), Formotol Tablets (E. L. Patch Company) and Cin-U-Form Lozenges (McKesson & Robbins). (Jour. A. M. A., October 4, 1919, p. 1077.)

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The Classical Amputations of the Foot and Ankle

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There are four amputations of the foot and ankle that may be termed classical. These are the Lisfranc, Pirogoff, Chopart and Syme. Each one of these has been named for the surgeon who first described the operation. The Lisfranc is a disarticulation of the foot through the tarso-metatarsal joints, the Chopart a medio-tarsal disarticulation, the Pirogoff an osteoplastic amputation in which the sawed off posterior portion of the os calcis is turned forward and upward against the tibia and fibula from which the malleoli have been removed, and the Syme an amputation through the malleoli just above the articular surface with the heel pad preserved for a bearing surface.

It is the object of this paper to briefly discuss the relative merits of these four amputations from the standpoint of function and artificial limb fitting.

The Lisfranc, when properly performed and sound healing obtained, is the most satisfactory operation of the four. With it a patient can have a block of wood, felt or rubber fitted in the shoe with hardly a perceptible deformity and function little less than normal for most occupations. Amputations of the foot anterior to the tarso-metatarsal articulations are superior to the Lisfranc because the farther forward the amputation the better the foot arches are maintained and the general balance of the foot preserved. Any good foot amputation can be satisfactorily fitted provided the site of amputation has not destroyed the tendon insertions of the tibiales and peronei muscles. It is necessary that the foot retain these tendon insertions to prevent its being drawn into the equinus

position by the strong posterior leg muscles.

The Chopart is the least satisfactory of the four amputations. The powerful calf muscles tend to draw the two tarsal bones backward and upward, making a prominent heel and a tilting downward of the scar, which often becomes tender. An un-

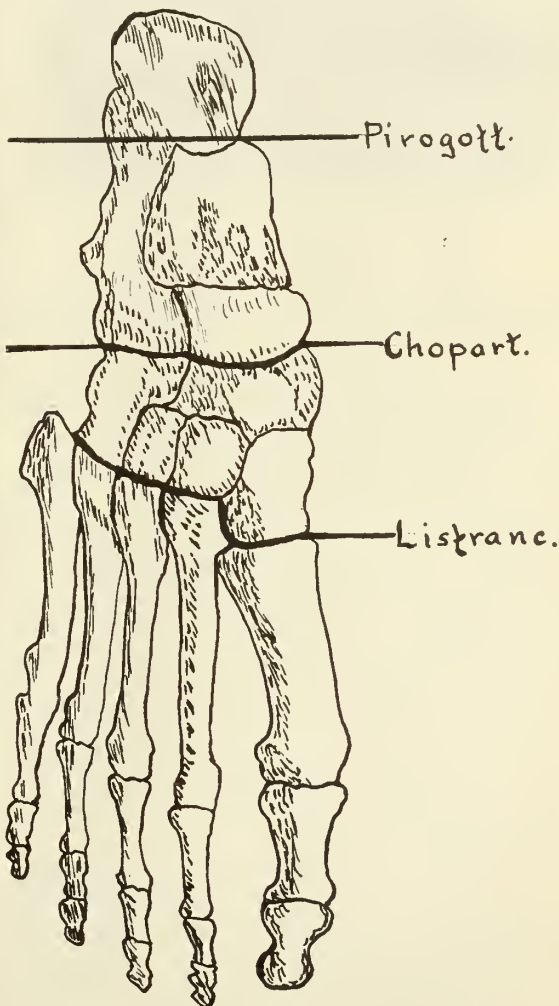


FIG. 1.—Skeletal sites of amputation of Pirogoff, Chopart and Lisfranc.

gainly apparatus, which is difficult to fit and more difficult to wear, is necessary for satisfactory locomotion. The loss of the anterior muscle insertions destroys the balance of the foot by leaving the unopposed calf muscles to constantly increase deformity. Many patients with Chopart amputations, after trying various types of artificial feet, return to the surgeon for reamputation. One well known artificial limb maker has told me that 75 per cent of foot amputations sooner or later submit to reamputation. Division of the tendo-



FIG. 2.—Chopart Amputation showing os calcis drawn back by contracture of calf muscles.

achilles, either at the time of the primary operation or later, may be of value but usually is effective for but a short time.

The Pirogoff amputation may make a very good weight bearing stump but it can never make a stump that is satisfactory to fit. It is too long to enable the limb maker to put an ankle joint below the end of the stump. If a movable ankle is made it must be fitted to the sides of the stump, giving the foot a large ungainly appearance. A second objection to this operation is that it is difficult to perform and get sound union between the os calcis fragment and the tibia. Often nonunion or malunion results. Unless a Pirogoff is perfectly done and perfect healing of both bone and soft tissues is obtained, the stump will be tender. The end of the stump is more pointed than the Syme and does not make such a good bearing surface.

The Syme amputation, when properly done, is a very satisfactory operation both from the standpoint of the patient and artificial limb maker. It is preferable to the higher leg amputation because the patient can walk about without any artificial appliance. This obviously reduces his disability. He can get up at night without

his artificial limb. When the limb is broken it is not necessary for him to resort to crutches. The advantages over the Pirogoff and Chopart are that it makes a good end-bearing stump; it can be fitted with an ankle joint; it is much easier to fit; and last, it has all of the advantages of the Pirogoff and Chopart with none of their disadvantages. But the Syme amputation may not always be free from difficulties. If the heel flap is left too long there is apt to result a wobbly tender stump. The flap may become displaced and tenderness result. If the flap is not properly shaped at operation the stump may be bulbous and difficult to fit. If proper care is not used in high division of the nerves, neuromata may form at points where pressure may make them tender. The circulation may be interfered with to such an extent that there may be sloughing of the flap.

I have sent a questionnaire to twelve of the leading artificial limb makers of the United States asking their opinions of the Syme, Chopart and Pirogoff amputations. Nine of these have replied. One states that the Syme and Pirogoff are equally easy to fit. The other eight are all emphatic in saying that the Syme is easiest to fit and decidedly the choice between the three. One maker states that he has a circular letter that he mails to all applicants having partial foot amputations saying that his firm or any other limb company cannot furnish a comfortable and satisfactory artificial appliance for such amputations. It is his experience that when a partial foot amputation is fitted by a firm it is the last order received from that locality. These patients try one artificial foot substitute after another from various makers without success and fin-



FIG. 3.—Same as Fig. 2 converted into a Syme because of tenderness and disability as result of deformity.

ally the vast majority of them resort to reamputation. Irwin¹ says "the ideal performance of this amputation (Syme) leaves a stump which is, from the point of view of function, as nearly as possible perfect." He has shown in a very instructive diagram that the capacity for work is much greater for the Syme than the Chopart or even the Lisfranc.

CONCLUSIONS.

1. The Chopart and Pirogoff amputations should be abandoned as definitive operations. The Syme has all of the advantages of them both without any of their objectionable features.

2. The Lisfranc amputation, when properly performed, is satisfactory both from functional and fitting standpoints.

3. The amputation of choice of foot or ankle proximal to the Lisfranc is the Syme.

¹Irwin—British Med. Jour., Feb. 22, 1919, No. 3034, p. 212.

Non-Tubercular Joints in Children

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My reason for writing on this subject at this time is to call attention, in a general way, to the observations that are being made in joint conditions in children.

About twelve years ago it was determined that scoliosis, the idiopathic type, occurred about the time of puberty, and was the result of softening of the bodies of the vertebræ. It is now thought that this change is produced by something being taken away from the bones to be stored up in the sexual glands. Whether or not this is true remains to be proven, for the condition may be due to a failure of proper ossification. Occasionally cases are seen in which the attitude of the spine is a posterior deformity instead of a lateral one and in all probability represents the same condition of the bones.

A year or so later all chronic conditions of joints, other than the spine, with evident bony changes, were diagnosed as tubercular and so treated. Some of these cases made very marvelous recoveries, while others went on and developed the usual crippling deformities of tuberculosis although treated by the same method. An investigation of some of these cases proved that the condition was often due to an improper development of the bone and not a joint disease at all, so that the so-called Perthes' disease has become an entity, and

is now quite frequently recognized. This condition is probably not a disease at all but represents a failure of the cartilaginous areas in the head and neck of the femur to harden or ossify at the proper time, with the result that they flatten out under the increased weight and strain they are called upon to bear.

That such a condition may be found at other joints is just being recognized, and now one occasionally sees a knee joint in which the bony change is analogous to that seen in cases of idiopathic scoliosis, and Perthes' hips. All of these conditions are characterized by changes of the cancellous structure of the bone resulting in softening. The joints are not involved at all, except as they are found to conform to the structural bony change. This fact makes the differentiation of these conditions from diseased joints rather easy by X-ray, although it may be necessary to delay in diagnosing certain early cases. As a rule the bony change gives rise to the symptoms and sufficient change will have occurred to make the diagnosis possible. An interesting feature of these cases is that the change usually comes on rather suddenly and often no definite symptoms are complained of, and it is the deformity that first attracts attention.

It is important that these cases be recognized early in order that they may be relieved of weight-bearing and their bones thereby given a chance to harden before marked deformity has occurred.

Infectious joints, secondary to infections elsewhere, such as tonsils or teeth, simulate tuberculosis very closely, and it is often difficult to differentiate between them. However, the X-ray can, as a rule, be relied upon to show no bony change in these conditions, whereas the bone is involved in tubercular processes. Early correct diagnosis in these cases will save the patients a long tedious treatment that will in the end be of no benefit to them, for, if the source of infection is removed, the joint symptoms disappear.

One other condition that I would like to mention is syphilis of the joints. In my opinion syphilis more closely simulates tuberculosis than any other disease. It is not uncommon for a case to be treated for two or three years as a T. B. joint and then found to be syphilis. It is a rather humiliating experience that is constantly occurring. The X-ray I think offers us a chance to make the distinction, and is in my opinion more reliable than the Wassermann. Syphilis is a rarefying disease but

not a destructive one. True you may have destruction produced by the functioning of the joint when the bones have been rendered soft by the rarefying process. The usual thing is to be able to make out the complete outline of the bone, and to see the rarefied structure. On the other hand tuberculosis is from the start a destructive process, the bone gradually undergoing a molecular death with an accompanying obliteration of the joint.

Just how much benefit will result from the antisyphilitic treatment in syphilitic joints in children is not known. Personally I have never observed a case that has in any way been improved by heroic treatment. We of course know that the periosteal and shaft involvement frequently shows marked improvement and much work needs still to be done to attempt improvement by specific treatment of the joint cases.

In conclusion I would like to urge, first, careful consideration of joint conditions in children; second, not to be in a hurry to make a diagnosis, and third, the treatment, if there is a bone involvement, follows the natural mechanical principles of weakened structures, viz: support and protection.

R The Chancre

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This paper will be devoted to the discussion of the histopathology of the chancre based upon the microscopic examination of fifteen excised Hunterian lesions.

A modification of the Levaditi silver impregnation method was used to demonstrate the *treponemata pallidæ* in the tissues. Hæmotoxalin Eosin, Van Gieson, and elastic fiber stain were employed to show cell relation.

A careful study of one mature chancre will reveal all the changes which take place from the time that the *treponemum* first gains entrance into the mucous surface until it disappears from the primary site. In this same chancre will be found all the basic principles of syphilitic pathology occurring in any other part of the body whether it be aortitis or hepatitis. So closely does the pathology of a syphilitic lesion of the aorta resemble that of a chancre that it is impossible in many instances to tell them apart were it not for the elastic tissue fibers. The *treponemata*

pallidæ are as numerous in the one as in the other.

It is a well known fact that the T. P. has a special predilection for the mucous membrane. By its own motility it enters an injured place, in these parts burrows down between the epithelial cells until it reaches the lymph spaces in the prickle cell layer, where the best anærobic conditions are obtained, and then begins to multiply. For some time it causes little if any disturbance, calling forth only a few leucocytes with which it lives in apparent harmony. In a few days the vanguard of its enemies appear, the small lymphocyte and the T. P. immediately moves outward and inward as it is never found where lymphocytes exist in any numbers. The lymphocyte infiltration becomes heavier until the epithelial cells above break down, and we have an open lesion. The lymphocytes are in turn replaced by large mononuclear leucocytes, and move our farther showing the T. P. in all directions from them. The large mononuclear leucocytes are in turn replaced by young connective tissue fibers. We now have at the farthest border of the chancre the *treponemata pallidæ*, next a band of small lymphocytes, then a band of large mononuclear leucocytes, and lastly connective tissue fibers. Of course these bands overlap a little at their junction, but the *treponemata* keep absolutely free from these other conditions and can not be found where any of these other changes have taken place. The induration of the Hunterian chancre is due to these changes.

The migration of the T. P. are in two directions, the great mass of them follow up the lymphatic channels involving each lymph node in turn until they reach the lymph nodes of the groins. From there on they gain entrance into the blood stream through the thoracic duct. The changes that take place from this point on are not in the scope of this paper. But while the main body of the T. P. have traveled the lymphatic way there are groups which break off from the main body early in the history of the lesion and pursue an entirely different course. These settle in the perivascular lymph spaces, pierce the blood vessel walls and gain entrance to the blood stream direct, are carried to different areas of the body, especially the skin, where they re-enact the same drama again, and we have the papular eruption of syphilis. These blood vessels suffer because of this invasion, and their resentment is shown by perivascular cell infiltration, thickened arterial walls and endarteritis. The old

scar of a chancre will retain these evidences of injury years after the lesion has healed. Thus it can be seen that a description of the pathological changes which take place in a chancre is a description of the changes which take place in any syphilitic changes, cell infiltration of the different types, connective tissue formation, endarteritis, periarteritis, giant cells and the production of gummas. The reason that the T. P. cannot be found in old syphilitic processes is because we examine for the presence of these organisms long after they have died or migrated to other parts.

—R—

Significance and Treatment of Hematemesis

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In the vast majority of cases, hematemesis indicates esophageal varices, due to disease of the liver or spleen, or cancer of the stomach, or peptic ulcer. Some of the rare causes are:

- (1) Poisons, such as arsenic, phosphorus, corrosive sublimate, carbolic acid, etc.
- (2) Constitutional diseases; scurvy, hemophilia, Bright's disease, and those diseases of the bile ducts associated with jaundice.
- (3) Specific fevers: Yellow fever, small pox, measles and influenza.

Occasionally patients that had been free from stomach symptoms vomit blood within a day or two following abdominal operations. The cause of the hemorrhage in such cases is supposed to be an injury to the omentum, but rupture of a small vessel in the gastric mucosa from vomiting and retching caused by the anesthetic seems a plausible explanation for some of these cases.

The difficulty in the diagnosis of the cause of gastric hemorrhage is indicated by the rather voluminous literature on the significance of such factors as appendicitis and cholecystitis, "Exulceratio simplex" Dieulafoy, the gastrostaxis of Hale White, and cases of severe hematemesis without an intrinsic lesion in the stomach. According to Eusterman¹ "two per cent of appendix cases and about five per cent of gall bladder cases with *marked reflex gastric symptoms* (italics mine) give a history of previous bleeding." Without a post-mortem examination to exclude an ulcer, such statistics are of little value.

Hematemesis in severe toxic cases, like appendicitis and cholecystitis, is attributed

by Dieulafoy to simple erosions of the gastric mucosa. Excepting in highly toxic states, when hemorrhage may occur from any mucous membrane, Dieulafoy's erosion should not be seriously considered as a cause of gastric hemorrhage.

Hale White reported twenty-nine cases of gastric hemorrhage in young girls without any lesion in the stomach, and called the condition gastrostaxis.

There are a number of case reports in the literature of hematemesis without an intrinsic lesion of the stomach. Most of these reports are by surgeons who formed their conclusions from inspection and palpation, without even opening the stomach to inspect the mucous membrane.

Moschowitz² reports four cases operated on in one month for severe hemorrhage and no lesion was found. In three of the cases he says: "Exclusion of ulcer must be with a certain amount of mental reservation." The fourth case was a child three and one-half years old and the "spleen was felt one inch below the costal arch." These findings are suspicious of von Jaksch's anemia.

Varices in the lower end of the esophagus, due either to cirrhosis of the liver or splenic anemia, are not an uncommon cause for hemorrhage, and a laparotomy will naturally not reveal the cause of the bleeding. Even at autopsy on such cases Preble says the opening in the vein may not be found unless the vessel is distended with air or water.

The difficulty in excluding an acute ulcer after the stomach is opened is indicated by the following statement by W. J. Mayo³: "Acute ulcer does not always show on the outer wall of the stomach, and the diagnosis may be clinical. Well marked symptoms, including hemorrhage, may exist, and yet a prolonged search of the gastric interior might be necessary in order to detect the lesion. Patients have bled to death from an ulcer so minute as to be discernible only with a lens at post mortem." This statement by Dr. Mayo should encourage surgeons to merely say that no lesion was found instead of concluding that no lesion was present.

It is evident that cases of hematemesis are pre-eminently within the province of the internist.

In the treatment of severe hematemesis the first aim is to stop the bleeding. Measures to prevent recurrences can be considered later.

Although the amount of blood lost may be considerable, often four to six pints, and

the hemorrhage may not stop for three or four days, the bleeding is seldom fatal. Excepting patients with cirrhosis of the liver, I have seen only one patient die from hematemesis. Reliable statistics show that nearly all patients recover temporarily, with or without treatment.

The mortality rate with the medical treatment by Mansell Moullin and Bramwell, quoted by Deaver,⁴ appears to be approximately correct. Moullin, in 153 cases of hematemesis in young girls, had only one death, and Bramwell in about the same number of cases experienced a mortality of 3 per cent. Most experienced surgeons contend that operation is indicated only in "certain cases." Moynihan states that only 3 per cent of cases are amenable to surgical relief. A patient that is almost exsanguinated is a poor surgical risk and the bleeding vessel is seldom found. Surgery should be limited to cases with recurrent hemorrhage, and the small number of these requiring surgery are better diagnosed without an exploratory incision.

The tendency being towards recovery, as coagulability of the blood increases while the hemorrhage continues, the effects attributed to the action of drugs may be questioned. However, the following measures are advised as the most rational treatment of sudden, profuse gastric hemorrhage:

(1) No food by the mouth for forty-eight hours. Water, one ounce every half hour. Water may also be given by proctoclysis or by hypodermoclysis. Ice by the mouth may be harmful by exciting peristalsis of the stomach.

(2) Codein, gr. 1, or morphine, gr. $\frac{1}{4}$, hypodermically if necessary for restlessness or fright.

(3) Adrenalin chloride 1:1000 solution, one drachm in two or three times as much water, every hour or two for two or three doses. It should not be given hypodermically.

(4) Silver nitrate, gr. $\frac{1}{4}$, in one drachm of peppermint water every three hours for four doses. This, as all remedies, should be given immediately after vomiting.

(5) Alkalies are extremely important to protect the thrombus in the bleeding vessel from the digestive properties of the gastric juice. A powder containing 20 grains of sodium bicarbonate, three grains of magnesium oxide and five grains of bismuth subnitrate should be given every hour, day and night, for forty-eight hours.

(6) Coagulen, a powder prepared from blood platelets, may be given by the mouth

in doses of one to two ounces of a 10 per cent solution.

(7) Lavage is indicated only when there is marked distention of the stomach, as the gagging due to introduction of the stomach tube may be harmful.

(8) Blood transfusion if the blood pressure drops to 80, or if the hemoglobin drops to 25, or if the hemorrhage continues in spite of other measures. In cases of emergency, a healthy blood relative can be used as a donor without tests for hemolysis or agglutination.

MEASURES TO PREVENT RECURRENCES

This depends largely on the correct diagnosis of the etiology of the hemorrhage. When the hemorrhage is due to a ruptured vein in the lower end of the esophagus, due to disease of the liver or spleen, medical treatment is futile while surgery may be applied in certain cases. When the bleeding is due to a gastric or duodenal ulcer, or to an erosion of the mucous membrane, which is usually an acute ulcer, if the rational medical treatment is given there need be little fear of a recurrent hemorrhage. Surgical indications in recurrent hemorrhages from the stomach are limited to two conditions:

First—Splenic anemia. When a young adult, with an absence of stomach symptoms, gives a history of repeated gastric hemorrhages, has a secondary type of anemia and an enlarged spleen, a diagnosis of splenic anemia is justifiable. For this condition splenectomy is the recognized treatment, and the results are fairly good, even after the development of ascites due to Banti's cirrhosis.

Second—Cirrhosis of the liver is not an infrequent cause of severe, recurrent hemorrhages from the stomach. In the recognition of this disease, a history of alcohol and an enlarged spleen are essential. W. J. Mayo has removed the spleen in six cases of cirrhosis, with one death and apparently good results in the other five. One object of the operation is to divert the blood from the splenic artery to the general circulation, as the usual cause for hemorrhage in these cases is esophageal varices, the result of increased pressure in the portal vein, splenectomy would seem to be rational therapy.

In peptic ulcer, recurrent hemorrhages are due to the corrosive action of the gastric juice. The relief obtained by gastroenterostomy in such cases is undoubtedly due to the lessening of the acidity, estimated by Patterson as thirty points, but the acidity can be easily and completely

controlled by alkalies and frequent feedings without subjecting the patient to the dangers of a major operation.

Probably on account of withholding food by the mouth for a few days, gastric hemorrhage is not an infrequent complication of gastroenterostomy for ulcer. According to Balfour,⁵ 12.7 per cent of the patients operated on for duodenal ulcer that gave a history of bleeding before the operation, reported bleeding after the operation. Five years ago Lichty⁶ made the observation in a number of ulcer cases, that alarming hemorrhages occurred immediately on withholding food by the mouth. In 1901 Lenhartz advised feeding by the mouth immediately as the best treatment for a bleeding ulcer, but he did not recognize the importance of frequent feedings or of alkalies.

For forty-eight hours following a severe hemorrhage it is best not to excite peristalsis by any kind of food. The acidity can be controlled by alkalies given every hour day and night. On the third day milk and cream, one ounce of each every hour from 7 A.M. until 9 P.M. The alkaline powder midway between feedings, and three powders thirty minutes apart after the last feeding. After a few days the diet may be gradually increased, but hourly feedings and alkalies midway between must be kept up for eight to twelve weeks. Following the plan advised by Sippy, clinical experience proves quite conclusively that the Sippy treatment, if properly given, is the only rational treatment for bleeding ulcer, as well as for all types of peptic ulcer, acute or chronic, obstructive or non-obstructive.

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Salvarsanized Serum Introduced Directly Within the Cranium

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The purpose of this essay is to discuss the subject appearing in the title, and re-

port in abstracted form two illustrative cases treated at the Bell Memorial Hospital. The space allotted demands brevity. For a fuller account of this subject-material I would suggest that those particularly interested request a reprint of the "Treatment and Study of Twelve Non-paretic Neurosyphilitics Treated by Intraventricular Injections of Salvarsanized Serum" by A. L. Skoog and Karl A. Menninger, published in *Journal of Nervous and Mental Diseases*, Vol. 50, No. 2, August, 1919.

During the past few years particular interest has been manifested in investigating syphilis, especially in the diagnosis and therapy in which neurologists have had a full share. Our diagnostic skill has been greatly increased by the Wassermann test, and examinations of the cerebrospinal fluid, particularly considering the pleocytosis, goldsol, and globulin tests, and the fluid pressure. During this same period we have shared in the fruits of Ehrlich's exhaustive researches which endeavored to find a compound of arsenic which would destroy to a maximum degree the spirochæta pallida and yet not exert a too toxic influence upon the patient treated. As a result the profession is quite well acquainted with salvarsan and neosalvarsan. A number of laboratories have been working with arsenic, trying to discover improved synthetic chemicals. Thus far none has been found to replace the two chemicals mentioned.

The men versed in the special peculiarities respecting the anatomy and physiology of the central nervous system, learn to use a considerable amount of caution when introducing any irritating chemical substance within the ventricles or sub-arachnoidean spaces of the brain and spinal cord. It has occurred to investigators that some germicide might be introduced directly within the ventricles or sub-arachnoidean spaces for special treatment of syphilis of the central nervous system in all its various stages. A few years ago Swift and Ellis reported a new method of introducing serum into the spinal canal, salvarsanized in vivo. At the time this was quite enthusiastically received. Since then a number of objections have been raised, and it is not used as extensively as formerly. Salvarsan and neosalvarsan have been introduced directly into the sub-arachnoidean space, but on account of the extreme sensitiveness of its linings only extremely small quantities, or highly diluted, can be used. Thus, the quantity of

the drug used is so small that the possible therapeutic value may be questioned.

During the past three years in conjunction with Dr. Curran, of the ophthalmological department at the University of Kansas Medical School, some special experimental work has been attempted in the treatment of the metaluetic disorders of the central nervous system, and particularly those with optic nerve atrophies. About two years ago Dr. Karl A. Menninger, then an interne on my service at the Kansas City General Hospital, treated twelve cases of late syphilis of the central nervous system, by means of salvarsanized serum, introduced into the ventricles. Some interesting results were obtained by this careful study.

The technique will be briefly outlined as follows: First, it seems hardly necessary to state that a careful neurological examination, including appropriate laboratory tests, should be made. The patient may be given salvarsan 0.3 to 0.6 grams by the usual intravenous method. For this treatment as large a dose as a patient will tolerate should be given. Thirty to sixty minutes following this treatment the patient should have removed from 80 to 300 c.c. of blood. The blood should be allowed to stand over night at the room temperature; then the serum is pipetted off or decanted off and inactivated for forty minutes at a temperature of 57 deg. C. It is preferable to have this serum clear; if a few red cells are present there is no objection. It seems hardly necessary to state that all of this procedure should be carried out under rigid aseptic conditions. Twenty-four or forty-eight hours after the treatment is begun, the patient is taken to the operating room, where under a local anesthetic a small trephine opening is made. Several points may be selected. Our choice is one which will permit the needle to be introduced into the posterior horn of the right ventricle in a right-handed subject. Hair is removed by shaving over a small area. A local anesthetic of 1 per cent apothesine introduced along the line of incision by means of a hypodermic needle will render all the tissues sufficiently anesthetic so that little or no pain is experienced. A 3 cm. incision is made directed downward and lateral from a point about 5 cm. posterior to the Rolandic area line and about 10 cm. from the middle line. As a rule all hemorrhage can be fully controlled by traction with two hooked retractors. The periosteum is incised and separated from the bone. A

small button of bone is then removed by means of the trephine. The needle is directed downward and slightly forward and inward. If the ventricular fluid does not flow readily, suction may be applied by using a glass syringe. As much ventricular fluid as possible should be removed. From 10 to 50 c.c. of the serum is now introduced slowly by means of a glass syringe. If the ventricle can not be readily entered, or no cerebral fluid obtained, the serum, in smaller quantities, may be introduced into the sub-arachnoid space by means of a specially bent needle.

It has been found, on a whole, that the seroums are less irritating to the ventricular cavity, compared with the sub-arachnoid space of the spinal cord. However, in many cases a considerable amount of reaction follows. I believe this to be due to a toxic ependymitis, choroiditis and meningitis. As a rule this lasts but a few days; in some cases it is almost entirely wanting. Evidences of this reaction are indicated by an increase of the temperature, pulse and respiratory rate, headaches, nausea and vomiting. In tabetics the lightning pains are often increased for a day or two following the treatment.

Case 1. This illustrates a case of well developed tabes with an almost complete optic atrophy, treated by the intra-ventricular method. He was an intelligent mechanic, 37 years old. His impaired vision began two years ago. At the time of treatment he had only a little light perception remaining. His ataxic gait and lightning pains were first noted eight months before the treatment. Much headache had been present. He did not give a history of an initial lesion. He had a marked Rhomberg, with patellar and Achilles reflexes absent. Before this treatment he had received six salvarsan injections. In October, 1918, he received his first intra-ventricular salvarsanized serum treatment. Subsequent treatments through the same original trephine opening were given at weekly intervals. In June, 1919, he reappeared for an examination, and showed a great deal of improvement, excepting regarding his vision, which had remained stationery. Three more treatments were given him at this time. His reactions following each of the seven treatments were mild. He was always able to be up and about in two or three days.

The results in this case indicate that had he been given this same treatment at the time of the earliest manifestation of the optic atrophy, an almost complete preven-

tion of his impaired vision might have been hoped for. Certainly all of his tabetic manifestations were much reduced. It should be borne in mind that neural fibers in the central nervous system can never regenerate after once being destroyed. The same law holds for the optic nerve, in that it is not strictly speaking a nerve but a projected portion of the central nervous system.

Case 2. This case illustrates one treated by the cerebral sub-arachnoidean method. This patient had been seen and treated carefully at Bell Memorial Hospital, by Dr. Ockerblad of the department of syphilology and Dr. Curran of the ophthalmological department. The patient was a railroad man, aged 37. He gave a history of having had a chancre seventeen years ago; some secondaries were manifested. He received prompt treatment for two months with mercury and iodide. When appearing in March, 1919, he suffered from a paralysis of the left eyelid, stating that this had been gradually occurring over a period of six months. Dr. Curran reported in his examination of January, 1919, that there was a complete paralysis of the left third, fourth and sixth cranial nerves. The left ptosis was complete. The pupils were irregular and there was very feeble light reaction. The Wassermanns on blood and spinal fluid were three plus. In August, when I first saw the patient, the eye condition was about the same as previously reported. The neurological examination resulted in the diagnosis of a late syphilitic cerebritis and meningitis. The patient was in a poor physical condition. In September, 1919, the patient was given four treatments with salvarsanized serum introduced into the sub-arachnoidean space. From 10 to 20 c.c. of the serum was introduced each time. This patient made a rapid improvement under this line of treatment in every way. His physical improvement was marked, his nervous manifestations greatly decreased, and his ptosis largely clearing up.

In conclusion I wish to recount a few of the interesting facts obtained by the work reported by Dr. Menninger and myself. In the twelve cases which we reported, four were vascular types of cerebral syphilis, two tabes dorsalis, one idiot, two tabo-paresis and five unclassified neuro-syphilis. The clinical results of the treatment showed a marked improvement in two cases, slight in six, and none in two; there was a fatality in two cases. Most of these cases were in extremis. The

laboratory showed, as a result of the treatments, that the Wassermann changed in the blood serum in 50 per cent, in the spinal fluid in 50 per cent, and the cerebral fluid in 80 per cent. The goldsol in the spinal fluid was diminished in 40 per cent and intensified in 30 per cent; and irregular in the cerebral fluids. This work indicates that there are striking differences, comparing the spinal and cerebral fluids in cases of neuro-syphilis. If any differences are manifested in the healthy state it has not been ascertained. The Wassermann reaction was different in six cases and agreed in six. The globulin was dissimilar in six and similar in five cases. The cells were always dissimilar. The goldsol reactions were dissimilar in eight cases and similar in four. This would indicate a possible interference in the channels of communication between the ventricles and sub-arachnoidean space of the spinal cord.

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Obstruction of the Common Bile Duct

MERVIN T. SUDLER, M.D.

Professor of Surgery, University of Kansas School of Medicine, Rosedale, Kansas.

The surgical treatment of diseases of the biliary tract now attracts a great deal of attention at the hands of the profession; and in spite of the great advance and the large number of operations done for the relief of this condition, the results are not uniformly as good as desired. This is a region difficult of access; manipulation is productive of shock and interference with the heart action; and the mortality, even in the most skillful hands in the country, is sufficiently high to emphasize its seriousness.

The most common cause of obstruction is stone, which has been very thoroughly and frequently discussed. There are practically three types of organic obstruction: (1) cancer, (2) cicatricial obstruction, and (3) spasmodic contracture of the muscles of Oddi (*Richter: Surgery, Gynecology, and Obstetrics, Nov., 1917*).

Curious as it may seem, carcinomatous degeneration of a duodenal ulcer is practically unknown; while malignant degeneration of ulcer of the stomach is fairly common. The characteristic symptom of cancerous obstruction of the ampulla of Vater is a gradually deepening jaundice without pain. Strangely enough, in these cases the biliary salts act to prevent the coagulation of blood and the danger of slow hemorrhage from the capillaries is

acute. Cicatricial obstruction is excessively rare; and since it is so rare, I wish to report the following case.

Patient, male, white, age 58, admitted to the hospital March 13, 1919, the diagnosis being obstruction of the common bile duct. Upon admission, the chief complaint was a dull aching pain in the pit of the stomach. The patient was badly jaundiced and his appetite was poor, but there was no constipation.

His difficulty began following an attack of influenza, five months previous to his admission to the hospital. At this time he was confined to his bed for six days. During the attack the patient had one chill, but there were no severe cramps. He states that he had a dull pain in the pit of the stomach three weeks before the onset of the influenza. The pain in the stomach subsided for a few days following the attack of influenza, but returned, and was accompanied by jaundice.

On January 11 he was operated upon in his home town for gallstones. The gall bladder was opened, but no stones were found. A drain was inserted. Following this operation the jaundice cleared up partially, though never entirely. It returned about a month and a half previous to his admission to the hospital, or about six weeks following the operation, at which time the wound had stopped draining. He had no serious trouble for a month; then he had a chill, accompanied by a severe abdominal cramp. This attack lasted for two hours, and was relieved by morphine. Following the attack, he vomited.

On April 3 the abdomen was opened by a Bevan incision. The common duct was found so large that it easily admitted the index finger. The gall bladder and duct were filled with mucus. The intestine and the ducts were carefully palpated, but no tumor or stone could be found. Apparently the duct had simply closed. An opening was made into the duodenum and the ampulla felt between the thumb and index finger. An anastomosis was then made. The line of suture was protected by having the omentum sewn around it. The gall bladder was opened, a purse-string suture was used so as to remove any tension on the other stitches, and a drainage tube was then inserted. The patient left the table in good condition.

On April 17 the patient was discharged from the hospital. At this time he was much less jaundiced, with bile showing in his stools. In October his physician reported him perfectly well.

In this instance there is absolutely no doubt of the obstruction; nor is there the slightest evidence of cholelithiasis at present or previously. It is therefore safe to assume that the obstruction was due to an inflammatory condition which resulted in stenosis. It is difficult to understand why an acute pancreatitis does not result in cases where the duct of Santorini is not present; especially when autopsies show that the most frequent cause of pancreatitis is an acute obstruction caused by cholelithiasis.

In regard to physiological obstruction: Its existence is purely speculative. Since we know that the bile remaining in the gall bladder often becomes thickened, that it may even contain a relatively large amount of mucus, and that its expulsion through the ducts produces colic pains very similar in character to obstruction caused by a gallstone or by spasmodic contracture of the muscle of Oddi, its differentiation would be very difficult. Reasoning by analogy, there is definite spasm of the pyloric muscle from hypersecretion in the stomach; and it is reasonable to suppose that under a somewhat similar condition in the gall bladder, there might be some spasm present in the muscle controlling the outlet.

—————R—————

The Etiology of Influenza

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Professor of Pathology and Bacteriology, University

In spite of the enormous volume of literature and exhaustive investigations on the recent epidemic of influenza, the micro-organism causing this disease has not yet been identified. While some of the work done has been purposeless and, because of inadequate controls or overenthusiasm, has often served to confuse the problem, yet the past year has resulted in a distinct advance in our knowledge of the causative factors in influenza. On the other hand it has also shown how little we know of the underlying processes of this dreaded disease.

In 1892, towards the close of the previous great pandemic of influenza, Pfeiffer described an organism—the so-called bacillus influenzae (also the Pfeiffer bacillus) which he believed to be the cause of the epidemic disease. Pfeiffer's view was not accepted by all investigators in Europe and, in fact, it was generally believed that he did not have sufficient evidence to substantiate his contention of the etiological

relationship of this organism. It was held by some that this organism caused the great pandemics and that the numerous small epidemics of so-called "grippe" were due to a variety of organisms. The matter was difficult to settle because of the absence of a great pandemic. However, the appearance of the pandemic of influenza in the fall of 1918 afforded an ideal opportunity for settling this controversy on the etiology of influenza. Unfortunately this work was necessarily handicapped by the disorganization of the medical and investigative forces of the country by the necessities of war and by the sudden and immediate call of the victims of the epidemic with its huge morbidity and shocking mortality.

Early in the epidemic the bulk of investigation consisted in determining the presence of *B. influenzae* and other organisms in the respiratory passages of the patients. The first reports indicated a high percentage of positive influenza findings. In one instance it was 98 per cent. This was followed by a period in which conflicting reports were received not only from this country but from all parts of the world, some showing a high percentage of influenza bacilli and others a low percentage with the predominance of either the pneumococcus or the streptococcus or other organism. Even Pfeiffer himself had difficulty in finding his bacillus in the cases that he saw. Apparently the predominating organisms differed in different localities suggesting that they were secondary invaders. To some workers this difference was ascribed to faulty technic; and negative findings were discounted by them.

Following this period came improvement in the method of isolating and cultivating the organisms resulting in a marked increase in its incidence in most localities; and at present, most investigators concede that it is the predominating organism, but there is a marked difference of opinion concerning its role as the etiological agent in influenza. Its frequent occurrence in the lesions indicates either a primary or a secondary role, but does not necessarily imply a causative part in the disease. It is well known that this organism occurs frequently in the throats of healthy persons, both during and between epidemics, and also that it is frequently present in other diseases; for instance, in measles.

The evidence in favor of *B. influenzae* being the cause of the disease is given below:

First—It is found in the respiratory pas-

sages more constantly than any other organism. Its presence in normal individuals and in other diseases is due to epidemic conditions whereby the existence of numerous carriers becomes inevitable. The mere presence of the organism is no proof of its etiological relationship any more than the presence of the bacillus of hog cholera implies that it is the cause. (The latter is due to a filterable virus.)

Second—The bacillus is toxic for animals with the production of lesions similar to those that occur in man. Formerly it was thought that laboratory animals were relatively insusceptible to it, but recent work has shown that some strains are very toxic for mice, rabbits, or guinea pigs, with lesions characteristic of influenza. Furthermore, the virulence may be increased by successive passage through animals. In rabbits a leucopenia is produced as in man.

Third—The influenza bacillus produces both an exotoxin and an endotoxin. The soluble toxin of some of the strains is very virulent and produces typical influenza lesions in the respiratory tract. Furthermore, rabbits may be immunized against this toxin with the production of an antitoxin that will protect another animal against either the toxin or the living organism of another strain. This toxin becomes more virulent if a pneumococcus or streptococcus be grown with the influenza bacillus. Injection of the toxin alone is apt to result in spontaneous secondary infections of the lungs with the pneumococcus or the streptococcus just as in man. Further evidence that the influenza bacillus produces a toxin is shown by the typical reactions following vaccination with the products of influenza bacilli. Some of the reactions resemble an abortive attack of the disease.

Fourth—The serum of influenza patients and convalescents contains specific immune bodies or antibodies against the influenza bacillus. These are in the nature of agglutinins, complement fixing bodies, and opsonins. Similar bodies are found in those who have taken the vaccine for influenza. Some workers contend that these serological reactions suffice to establish the etiological relationship of the influenza bacillus. However, inasmuch as this disease is characterized by so many secondary infections, such immune reactions should be interpreted with caution, because they only indicate an infection with the influenza bacillus, which may be a secondary process and have no bearing with the pri-

mary and underlying cause.

Those who do not accept *B. influenzae* as the primary cause may be divided into three groups: (a) Those who are in doubt as to the nature of the organism; (b) those who believe that the disease is due to a filterable virus and that the influenza bacillus is only a secondary invader; and (c) those who believe either that the streptococcus or pneumococcus alone or in symbiosis with the influenza bacillus causes the disease. In addition there are a few who believe that the micrococcus catarrhalis and allied gram negative diplococci play an important role. The main objections to the Pfeiffer theory are as follows: (1) Influenza bacilli are not always found in the lesions and are found in healthy persons and in other diseases such as other respiratory infections, and in measles, a disease that simulates influenza in its acute onset, short incubation period, leucopenia, contagiousness and tendency towards pneumonic complications.

(b) The pathogenic action of the influenza bacillus on animals is not proven. Many workers have failed to produce death of inoculated animals except in symbiosis with other organisms or in massive doses. The subjective nature of so large a part of the influenza infection and the absence of any very specific character in the lesions in the respiratory tract renders the interpretation of the lesions in animals as specific for influenza difficult. It has been shown, however, that if the respiratory epithelium is first injured in some way, for example by exposure of the animal to poisonous gases such as chlorine or phosgene in low concentrations, the influenza bacillus then exerts a very pathogenic action with apparently characteristic lesions.

(c) The symptoms following the injection of the influenza vaccine does not necessarily imply a specific reaction, as it may be more of a protein reaction. This is supported by the fact that, in one series at least, there was no leucopenia such as occurs in influenza patients.

(d) The occurrence of antibodies in the sera of influenza patients and convalescents has received undue significance. Some investigators have failed to detect such bodies. In this connection it should be remembered that these substances are transitory in character, being present but a short time and disappearing early in convalescence. One worker found antibodies in the sera of influenza patients against a variety of organisms, in fact they were more constantly present for streptococci

than for *B. influenzae*. For example, complement fixing bodies were more frequent against a strain of the streptococcus (70 per cent) than against *B. influenzae* (20 per cent). This was confirmed by another investigator. There is considerable variation between different strains of the influenza bacillus, some manifesting no reaction with the patient's sera.

As Park has pointed out, an epidemic strain is alike everywhere in cases arising in the epidemic, therefore the serum of an animal immunized against a particular strain should show antibodies for all other strains isolated from that epidemic as well as for the organism used for immunization. In other words, if the influenza bacillus is the cause of the recent epidemic, the serum of a rabbit immunized with one strain should react with all other strains isolated from the victims of the epidemic. If this does not occur, this organism cannot be considered the cause of the disease. About 100 strains isolated from various sources were tested in Park's laboratory with this object in view, but all were found to react differently, indicating that the bacilli were present before illness and that some other virus created conditions that allowed the latent bacilli to exert a pathogenic action; in other words, the influenza bacilli were secondary invaders.

The idea that influenza may be due to a filterable virus received impetus in the report of Nicolle and LeBailly who succeeded in producing the disease in man and monkey by inoculation with the filtered virus from the nasopharyngeal secretions. While suggestive, these experiments were inadequately controlled and are therefore inconclusive. Similar results were reported by some English observers (Gibson and Connor), but in the United States where they were attempted by several independent investigators, the results were uniformly negative.

Recently, British observers (Bradford, Bashford and Wilson) isolated from all of their influenza cases a minute, filterable, anaerobic, coccoid organism, cultivated by Noguchi's method. It was found in the sputum, nasopharyngeal secretions and in the blood early in the disease. It could be passed through animals successively with characteristic lesions in the respiratory tract and the organisms could be isolated from the lesions in pure culture. These authors maintain that the disease is primarily a blood disease; that is, a bacteremia with localization of the lesions chiefly in the respiratory system. The or-

ganisms persist in the sputum and other excretions a considerable period. The use of this organism on human volunteers had not been attempted, but should give conclusive results.

Human experimentation has been carried on by a number of observers, but with disappointing results. The use of filtrates of the sputum and nasopharyngeal secretions of influenza patients failed to produce the disease in the hands of McCoy, Nuzum, Wahl and Rosenau.

Wahl, White and Lyall sprayed filtrates of pneumonic lesions of fatal cases of influenza in the nares and nasopharynx of several volunteers, with negative results. They also used heavy emulsions of young living influenza bacilli in the same manner without the production of any illness or any abnormal change except the addition of influenza bacilli to the nasopharyngeal bacterial flora. These organisms were isolated from their throats for several weeks after the inoculation. None of these men showed a leucopenia. One of the strains used was just obtained from a fatal case of influenza and should have been virulent. None of the men had had influenza.

Rosenau performed a more thorough series of experiments on human volunteers but with equally negative results. In spite of using almost every method conceivable to propagate the disease under apparently very favorable conditions, he failed. He had at his disposal 100 volunteers, none of whom had influenza, and carried out the following sets of experiments:

(a) Insufflation of living influenza bacilli in the nasopharynx and nares of nineteen volunteers.

(b) Direct transference of the nasopharyngeal virus and secretions to ten men. A portion was filtered before use.

(c) Intravenous injection of the patients' blood.

(d) Transference of freshly inoculated swabs of many patients to nineteen volunteers.

(e) Direct exposure of each of ten volunteers to the breath and respiratory discharges of each of ten selected patients, allowing the latter to cough in their faces.

Such strikingly negative results make the search for the causative organism discouraging. Apparently some other factor, unknown at present, plays a part. It may be that the volunteers were insusceptible, but it is strange that all of these men, chosen largely because they were apparently susceptible, should prove to be uniformly highly resistant. Such results as

these just noted emphasize the need of conservatism in the interpretation of animal, bacteriological and immunological experiments. It is unfortunate that in these experiments Rosenau did not include a series to show the effect of using soiled eating utensils of the patients, which Cummings emphasizes as a very important mode of transmission of the disease.

—R—

Chlorinated Highballs for Polish Soldiers

The beverage with which the A. E. F. was long familiar, the "chlorinated highball," will soon be extensively drunk by the Polish troops under Generals Pilsudski and Haller. But it isn't as intoxicating as it sounds, for it doesn't come out of a cask or a bottle or even a little stone jug. It comes out of a waterproof fabric bag with faucets around the bottom, known to the soldiers as the doughboy's life-saver, and to medical men as the Lyster bag. Slow evaporation through the canvas, when the bag is hung out of doors, keeps the water cool, and a tube of calcium hypochlorite broken into it makes it safe for drinking.

Last summer the Polish army called upon the American Red Cross for assistance in improving health conditions in its camps and military centers. Purification of drinking water is something that has never before been practiced in the Polish army. The troops were dependent upon whatever natural water supply was at hand and were thus exposed to infection. As a first step in starting health improvements, the Red Cross pointed out the advantages of the Lyster bag, and following their suggestion Polish chemists made tests of its action and indorsed it highly.

As a result the Minister of Health ordered 20,000 of these bags, together with the necessary ampules, for use in army camps, and at civilian refugee centers.

—R—

Influenza

What he considers as a unique case of epilepsy or epileptiform convulsions following a severe attack of influenza in a child, two years old, is reported by L. P. Clark, New York (Journal A. M. A., December 6, 1919). Both grand mal and petit mal attacks occurred almost daily for two weeks. The occurrence of dentition seemed to render the convulsions more severe, and mental development was retarded, temporarily. At present the attacks are less frequent and of the petit mal type, and the child is improving under hygienic, dietetic and moral treatment.

THE JOURNAL

of The

Kansas Medical Society

W. E. McVEY, M.D. - - Editor

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Goin' On Twenty

This number completes the nineteenth volume of the Journal. At its birth it was a sorry infant. Apparently it had neither father or mother, but like Topsy it "just growed." For the first two years of its life it had not even a nurse to look after its care and needs, but in some way it survived and at the end of its second year some benevolent friends took pity on it. It was clothed in fine raiment, was carefully and wholesomely nourished and in a few short years had grown into a promising youth.

Its existence was still precarious, however, for the state society journal idea was not very deeply rooted at that time. It had to meet much opposition and strong competition. But once well rooted the idea began to grow and at this time the state society journals are in the ascendancy and it is the independent journal whose existence is precarious.

As one of the pioneers in this particular field the Journal may be proud of the fact that it is now one of thirty state society journals that are making a creditable showing for themselves and have practically revolutionized the ethics of medical journalism.

We realize that there is much room for improvement in the Journal and plans are already made for features that will add to its interest and value. As soon as the paper market will justify it will be enlarged, but in the meantime the material will have to be crowded into the smallest possible space.

One of the things the Journal most lacks is co-operation by the secretaries of county societies. It should have a column of news items each month—items about the members of the Society, including deaths, marriages, removals, etc.—but in order to have such a column the secretaries must send in the items.

We should have several columns each month from the Medical School giving the members something in regard to the work going on there. This we hope to have during the coming year.

There are other things the Journal should have and should do. Some of them will appear during the next year and others will appear as conditions permit.

Since this is its last appearance before the holiday season the Journal wishes you all and all yours a Merry Christmas and a Happy New Year.

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A Medical-School Number

Most of this issue is filled with contributions from members of the faculty of the clinical school at Rosedale. It is essentially a Medical School number. We hope that every member of the Society will read these papers. We hope you will read them because they are well worth reading, and also because from these papers you will get a better idea of what the medical school is doing in medicine.

The school is entitled to the co-operation and support of every member of the Society. With your hearty co-operation it will grow in importance both to the profession and the people. Whatever you do for it now will be well repaid in the benefits which all will derive from a high class medical school and the progress in medicine which such an institution stands for.

Larger and Better Societies

Has your society enough members to justify its existence as a society? If all the eligible men in your county were members would your society be large enough to have regular meetings and regular programs? These are questions that deserve consideration.

If your society is a small one and there are enough eligible men in your county to make it a large and active organization, why are these men not members? If with all the eligible men in the county your society would still be too small to be of much importance or of much interest, why not combine with a neighboring county, or with two counties, or a half dozen counties, and have a *real* society, one you will be glad to be a member of, one that will have meetings every month and programs that are worth while, and one to which every physician in the territory will wish to belong?

There can be no doubt that such organizations would show much greater activity and would total a much larger membership than would several small societies occupying the same territory. It is not necessary that the counties so combined shall be in the same councilor district. Rather should the convenience of railroad connections with available meeting places be the determining factor.

Errata

In the article on "Post Operative Use of Radiant Heat" by Dr. L. A. Sutter, which appeared in the November number, the word *fermentation* occurring in the fourth and twelfth lines in the second column on page 265 should be *fomentation*.

Dr. Wilbur A. Baker, formerly serologist for the Public Health Service and pathologist for the Kansas University at Rosedale, is now associated with the Risdon-Sterrett Clinic at Leavenworth.

It has been hinted to us that the Council and officers of the State Society are to be entertained by the Wyandotte County Society at their annual meeting in January.

The Wyandottes are a spirited and energetic lot of fellows who know how to entertain themselves and their friends. They have a good society and are rather proud of it.

MEDICAL SCHOOL NEWS

Reopening of Public Health Laboratory at University of Kansas, Rosedale

Through the combined efforts and financial sacrifices of the Medical School of the University of Kansas and the U. S. Public Health Service, the Public Health Laboratory for the prevention of venereal disease has been reopened.

From the first of the year the laboratory will be prepared to run Wassermann tests and to examine urethral smears, free of charge. Any doctor in the state wishing such work done will, upon application, be furnished with sterile containers and mailing cases for blood samples.

In order for the laboratory to be of service both to the doctors and the people of the state, and at the same time furnish statistics for the Public Health Service of the incidence of venereal disease in the state, it will be necessary for all cases to be reported to the office of the Public Health at Topeka by the doctors.

D. R. BLACK, M.D., Director.

To the Alumni of the Medical School of the University of Kansas

It will be of interest to all the alumni of the Medical School of the University of Kansas, either by virtue of direct graduation or having graduated from one of the various schools which consolidated to form the present Medical School of the University of Kansas, to know that a permanent alumni association has been formed.

Prior to the date set for a permanent organization, letters were sent to all alumni whose names and addresses were at hand. These letters urged all members to come to the meeting on November 26, 1919, at the University Club, Kansas City, Missouri, and help put the association on a sound footing. Many members responded and we had a very successful session. The following officers were elected:

President, Dr. C. B. Francisco, Kansas City, Mo.

Vice Presidents—Dr. Thomas Hyatt, Topeka, Kan.; Dr. J. P. Kanokey, Kansas City, Mo.; Dr. D. W. Basham, Wichita, Kan.; Dr. G. M. Gray, Kansas City, Mo.

Secretary and Treasurer, Dr. D. R. Black, Bell Hospital, Rosedale, Kan.

Executive Committee—Dr. C. C. Nesselrode, Kansas City, Mo.; Dr. J. M. Frankenburg, Kansas City, Mo.; Dr. Rex L. Dively, Kansas City, Mo.; Dr. R. W. Holbrook, Kansas City, Mo.; Dr. J. L. Myers, Kansas City, Mo.

The purposes for which the organization will work are the following:

1. To help our alma mater through the present difficulty.

2. To make the graduates of all the consolidated schools feel that they have a common parentage in the University of Kansas.

3. To establish an annual homecoming week at the Medical School where clinics may be held and interesting subjects discussed by various members.

4. To assume a personal interest in the future development and progress of the school.

In the very near future circular letters will be sent to all the members whose names and addresses are at hand, urging them to join and help to make the Alumni Association a real success.

All of us know that a university can be no stronger than its alumni, so it is up to all to get into the harness and put our alma mater on the map.

Unfortunately a complete list of the graduates with proper addresses is not available, so if you fail to receive a letter, send in your name, address, date of graduation, and from which school, and enclose \$1 for annual dues for 1920.

D. R. BLACK, Sec'y & Treas.,
Bell Hospital, Rosedale, Kan.

The Hospital Fund

Subscriptions for Purchase of Additional Ground for Bell Memorial Hospital

Geo. Rushton Baking Co.	\$ 250.00
L. H. Rose & Son.	250.00
Rosedale State Bank	250.00
Dr. Sudler.	250.00
Inter-City State Bank	250.00
Commercial State Bank.	250.00
H. W. Gates	250.00
Gov. Henry Allen	250.00
Dr. E. J. Curran	250.00
Dr. A. C. Classen	100.00
Holsinger Bros.	100.00
Dr. P. J. O'Connell	100.00
Dr. B. M. Barnett	100.00
Dr. C. E. Sanders	100.00
Dr. O. M. Longenecker.	100.00
Dr. W. D. Smith	100.00
Dr. Arthur E. Hartzler	100.00
Jno. J. Naschold	100.00
Dr. Klepinger.	100.00
Bert Chronister	100.00

L. R. Jewell	100.00
Otis S. Durbin	100.00
Mrs. B. Chronister	100.00
Junior Class, K. U. Medies.	100.00
K. U. Medie Nurses	100.00
Mank & Dammann	100.00
Kimball Milling Company.	100.00
Elliott & Godfrey	100.00
Prince-Johnson.	100.00
Anonymous.	100.00
Mrs. L. H. Rose	100.00
Frank Rushton	100.00
William Hampton	100.00
Berkshire Lumber Company	100.00
Ethel Haines	75.00
Clyde Leavengood	75.00
D. C. Stockton	50.00
Mrs. B. L. Stine	50.00
Elizabeth Talle	50.00
David Buckland	50.00
J. R. Stanley	50.00
S. H. Rennie	50.00
Dr. R. W. Swinner	50.00
Thomas Wray	50.00
Miss Kate Noble	50.00
Miss Grace Scott	50.00
Mrs. Ehrman	50.00
Mrs. M. J. Filkin	50.00
First M. E. Ladies' Aid Society.	50.00
A. Naylor	50.00
E. G. McDonald	50.00
C. G. Barben	50.00
Knoche Bros.	50.00
Newton & Son	50.00
Heady & Son	50.00
Schanze Furniture Company	50.00
A. T. Stewart	50.00
George Gerner	50.00
H. Ringer	50.00
J. R. Kaufman	50.00
P. J. Byrne Lumber Company.	50.00
Jennings & Son Company.	50.00
American Crushed Rock Company	50.00
Frisco Elevators	50.00
Zip Manufacturing Company	50.00
Gerner & Slater	50.00
James Carroll	50.00
Robert Carroll	50.00
L. V. Williams	50.00
Baptist Ladies' Aid Society	50.00
P. J. Goulding	50.00
J. P. Jensen	50.00
J. M. Killmer	50.00
Samuel and P. Clasen	50.00
Dr. Stewart	50.00
George Holsinger	20.00
Mr. and Mrs. George Rushton	20.00
Troop 4, Boy Scouts	20.00
S. T. Roush	15.00
Frieda Kampschmidt	15.00
L. M. Smith	15.00
Dr. P. J. O'Connell	15.00
Mrs. C. E. Sanders	15.00
A. H. Ebert	10.00
Rev. W. D. Kelley	10.00
Rev. I. P. Frazier	10.00
Rev. J. E. Scheer	10.00
E. C. Holt	10.00
Myers Bakery	10.00
Hans Prinds	10.00
Mrs. George Rushton, Sr.	10.00
Mrs. Don Carlos Guffy	10.00
Neal Dabney	10.00
George Gerner	10.00
Mrs. B. L. Stine	10.00
George Maddox	10.00

Luther Leavengood	5.00	J. W. Skaggs	1.00
Mrs. Myrtle M. Wright	5.00	Total	\$9,415.40
Mothers' Club, Columbian School	5.00	In order that the facilities of the hospital and dispensary may be developed to the highest point and used to the best advantage, a committee of the faculty have been appointed to make a comparative study, according to the standards of the American Medical Association. The committee is now at work on this important matter of seeing just what can be done to bring this work in absolute correlation with these standards.	
R. W. Long	5.00		
H. M. Withers	5.00	It is very gratifying to note the loyalty of the alumni of the institution at this time. It is understood that a number of them have subscribed \$50 and \$100 and other such sums for the purchase of the necessary land for the building of the new hospital. Their list is not yet ready for publication.	
Louis Helmreich	10.00		
Miss Mary Callahan	5.00	————— R —————	
Edith Mathias	5.00		
Edna Jones	5.00	Fables for the Kansas Doctor	
Mrs. H. H. Brooks	5.00		
Mrs. S. R. Williamson	5.00	By RENNIG ADE	
Joe Trabon	5.00		
Earl S. Warner	5.00	Once upon a time there was a Kansas doctor who dispensed his own medicines. He was very trusting and believed implicitly what the veteran drug salesman, aged 24, told him concerning the therapeutic qualities of the products he sold. He would sit in rapt wonder and astonishment while the aforesaid salesman graphically recited the results obtained by Dr. Squint of Rustic Center, Arkansas, in the treatment of two cases of tonsillitis with the Bilcatone Serum. It never occurred to him to doubt the scientific source of the case reports, nor to perceive the commercial acumen of the manufacturers. He always bought a good supply of the serums, vaccines, etc., and was continually looking for a case to fit his last purchase. In buying his medicines he used better judgment and made it a rule to purchase proprietaries the name of which suggested the use for which they were intended. For instance, Rheumaxitone was good for rheumatism, Cascarhea obviously would produce free catharsis, Stomatone would cure all diseases of the stomach, etc. Sometimes he would forget the therapeutic uses of a five-gallon lot and then would have to wait until the drug salesman came around and enlightened him.	
Sidney Williamson	5.00		
Verne Holt	5.00	On one occasion he made the mistake of giving Liquor Erectum to an elderly gentleman who was suffering from hemorrhoids, an error that might easily occur as the letter E had been torn off the label. The terrible mistake was discovered early	
Wilburn Smith	5.00		
Phillip Cessna	5.00		
Dr. C. E. Sanders	5.00		
George Stanley	5.00		
Rev. J. E. Scheer	5.00		
——— McElheney	5.00		
I. O. O. F. No. 477	5.00		
A. J. Poor	50.00		
Columbian School	25.00		
Shuff & Campbell	25.00		
J. V. Preston	25.00		
Bertha Byerley	25.00		
H. Chilton	25.00		
L. M. Myers	25.00		
Mrs. G. W. McNatt	25.00		
Kyte Bros.' Grocery	25.00		
Davidson Manufacturing Company	25.00		
W. P. Lambertson	25.00		
Adolph Strasser	25.00		
R. W. Ducan	25.00		
L. R. Gates	25.00		
H. H. Brooks	25.00		
W. L. Vance	25.00		
Mrs. H. P. Myers	25.00		
Mrs. D. D. Miller	25.00		
Sam Brooks	25.00		
Mrs. George E. Rose	25.00		
Gladys Harding	25.00		
Mrs. M. E. Mann	25.00		
Edna Holsinger	25.00		
S. R. Williamson	25.00		
Roy Vance	25.00		
Blanche Stockton	25.00		
Benjamin Barnett	25.00		
McMurray Construction Company	25.00		
C. J. Johnson	25.00		
William C. Lunt	25.00		
J. B. Dentler	25.00		
H. C. Alves	25.00		
Security State Bank	250.00		
Don Carlos Guffey	250.00		
Thomas G. Orr	100.00		
O. J. Cunningham	100.00		
Dr. D. R. Black	100.00		
Dr. O. J. Cunningham	100.00		
Dr. Howard Marchbanks	100.00		
Drs. Colt & Colt	100.00		
Dr. W. A. Myers	50.00		
Dr. Frank L. Abbey	50.00		
Dr. J. Milton Singleton	25.00		
Dr. L. A. Lynch	25.00		
John B. Smith	25.00		
Whitmore School	17.40		
G. L. Baughman	10.00		
Martha A. Thompson	10.00		
V. F. Boor	10.00		
Elmer E. Liggett	10.00		
W. H. Stalmaker	5.00		
Dr. H. S. Butler	5.00		
Walter Bryant	2.00		

the next morning by the hired girl when she called him for breakfast. Fortunately only one dose had been taken. However, so potent was this formula, the old gentleman, who had been suffering also with *glandular interstitialis indifferencia*, was immediately restored to pristine vigor and when last heard from was traveling for a millinery house out of St. Louis.

Some of the compounds he bought took on fearful and wonderful changes. A nice green tonic would settle down over night into a muddy colored mixture and he could then appreciate what the salesman had meant when he had called it a *stable* preparation. Sedimentation and fermentation vied with each other for supremacy in the drug room and the pop of flying corks attested the fierceness of the conflict. A modest office girl who was reaching for a bottle on a high shelf was struck in a vital spot by a cork out of the Elixir Sedative bottle which was standing on the floor, and was only influenced to withdraw a damage suit after much persuasion.

At another time a revenue officer climbed on the roof and sniffed the better part of the night at a broken window in the office. He always invoiced this stuff as *drugs and fixtures* and almost succeeded in unloading it one time on a doctor from South Carolina who was looking for a location for his wife's mother's kidneys. He would probably have gotten by if he had not attempted to slip in a static X-ray machine and a nebulizer. The prospective purchaser took fright at this and left town on the first train. Later on the doctor succeeded in giving the static machine to the high school and received favorable mention in both the town papers as a result.

The nebulizer was shuffled from pillar to post and ultimately became the property of two little girls who used it in their play house for a fire extinguisher. His granules and pills became weather-bleached and hardened and could have been used over and over if some method had been perfected to save them. He was oftentimes surprised and embarrassed to have some thrifty patient bring back a dozen of the pills that had been taken strictly according to directions and request a rebate on his account. Frequently these were the friable pills that the salesman had easily crushed between his thumb and forefinger. Later when he bought a half interest in the drug store on the corner the doctor's drugs were moved behind the prescription case. The sounds and speculum were arranged alongside the operating chair, the latter being

used for wall paper customers, and the fixtures were thrown into the cellar.

The doctor soon learned to practice medicine more successfully by closely observing his partner, the druggist, who had been practicing on the sly for twenty years. He learned that it didn't take much mental effort to wrap up a bottle of Hostetter's Bitters for a tonic, especially when the patient knew what he wanted.

He also learned that a bottle of lemon extract could be sold at 40 cents cash and more profit made than on a sixteen-ounce bottle of White Liniment that was never paid for. He learned to wrap up the wormy glycerhiza quickly and only sold it to old people whose eyesight was poor. He became accustomed to handling money and complained every time he put the 1-cent government tax to one side when he made a soft drink sale. This only left him a 14-cent profit on each 17-cent transaction and as a result he was getting prejudiced against the government. The Sympathetic Society of Non-Bathers who made his store their headquarters agreed with him that something ought to be done. Thus gradually the doctor got on a firm financial basis. The banker slapped him on the back more often, but the little boys and girls with the big trusting eyes seemed to pay no attention to him any more.

Moral.—Poverty and credulity are not without reward.

R SOCIETY NOTES

SHAWNEE COUNTY SOCIETY

The annual meeting of the Shawnee County Society was held at the Elk's Club on Monday evening, December 1. The old custom of having a real banquet on the occasion of the annual meeting was revived.

As the clock struck seven the doors of the banquet room were thrown open and the members and their guests were promptly seated. One hundred and twenty-three plates were served.

Between the first and second courses the society was called to order by the president, Dr. F. L. Loveland, and the following officers were elected: President, W. M. Mills; vice president, A. K. Owen; secretary, E. G. Brown; treasurer, L. H. Munn; member board of censors, W. E. McVey.

Beautiful roses and delicious candy were provided for the ladies, and cigars and cigarettes for the gentlemen. At 8:30 the society adjourned to the Grand Opera House where seats had been provided to

witness a comic opera production. Fortunately all had been well fed and were in a charitable mood.

WYANDOTTE COUNTY SOCIETY

The Wyandotte County Society met at Carnegie Library, Kansas City, Tuesday evening, November 18.

A paper was read by Dr. Robert A. Davis on "Points in Treatment of Epidemic Cerebro Spinal Meningitis."

MEADE-SEWARD COUNTIES SOCIETY

The Councillor of the Twelfth District, Dr. W. F. Fee, issued a call to the doctors of Meade and Seward counties to appear at his office in the city of Meade for the purpose of organizing a medical society. Dr. Fee read a letter from the president of the State Medical Society urging that he organize one, or more than one, as he deemed best, in the Twelfth District. After some preliminary work Dr. Fee was called to the telephone and, from what I could understand from the conversation, it was a call to refreshments, for Dr. Fee in his most amiable way invited us to follow him, which we did. Landing at his beautiful residence, we were introduced to his wife and daughters and then ushered into the dining room, where we were served so well I have forgotten the number of courses, but I do know that the table was loaded with everything that a person could wish. All present admitted this to be one of the best feeds they had ever attended. Many thanks to Mrs. Fee and her charming daughters, and I assure them they will never be forgotten by anyone present. After dinner we returned to the office of Dr. Fee and resumed business. The first being the election of officers for the remainder of 1919 and the coming year 1920. Dr. A. L. Knisley was chosen president; Dr. A. M. Morrow, vice president, and Dr. J. W. Messersmith, secretary-treasurer, all of Liberal, Kansas. Dr. Knisley gave a nice talk on some of his experiences while in the army, which was very interesting and instructive. Drs. F. W. Huddleston, George A. Nickleson, C. B. Lesley, A. M. Morrow and W. F. Fee also gave some very interesting talks. A motion was made by Dr. Lesley that all of the old members of these two counties be elected members of this society, and the motion carried. Dr. J. C. Roab, of Fowler, and Dr. George S. Smith, of Liberal, were unable to attend. This society shall be known as the Meade-Seward Counties Society. After spending the evening in a most pleasant manner they decided to meet in the city of Liberal

some time during the holidays.

J. W. MESSERSMITH, Sec'y-Treas.

DECATUR-NORTON COUNTY SOCIETY

The Decatur-Norton County Society met in Norton on November 25 at the Commercial Club rooms. The following program had been prepared for this meeting:

"Some of My Experiences in the A. E. F. in France," H. O. Hardesty, Jennings.

"Treatment of Empyema," F. D. Kennedy, Norton.

"The Sanatorium Treatment of Pulmonary Tuberculosis," J. A. Milligan, chairman Advisory Commission, State Sanatorium for Tuberculosis, Garnett.

"Cholecystectomy vs. Cholecystostomy," Wm. C. Lathrop, Norton.

"Influenza," S. J. Crumrine, secretary State Board of Health, Topeka.

"When Should the Tonsils Be Enucleated?" J. L. Shewmaker, Phillipsburg.

"Hyperthyroidism," F. H. Smith, Goodland.

Round table.

General discussion followed each paper.

DEATHS

Dr. T. F. Foncannon, aged 63, died at his home in Emporia November 20, of Bright's disease. He had been totally disabled, being unable to leave his room for three or four years.

Thomas Franklin Foncannon was born in Montgomery, Indiana, March 15, 1856, graduated from the Louisville Medical College, Louisville, Kentucky, in 1878. He located in Emporia in 1884 and has practiced medicine until disabled by illness. He was for many years an active and energetic member of the Society.

Dr. J. J. Kackley, aged 93, died at the home of his daughter in Chetopa, November 4, 1919. John Jefferson Kackley was born November 18, 1826, in Muskingum County, Ohio. He graduated in medicine from what is now Washington University Medical School in 1871. He moved to Chetopa in 1874 and practiced medicine there until forced by advancing years to retire.

Dr. Lemuel Stephen Coplan, Wellington, Kansas, aged 51, died in Chicago, November 17, from atrophic cirrhosis of the liver. Dr. Coplan was a captain in the Medical Corps of the army and was honorably discharged December 12, 1918. He graduated from the University of Illinois Medical School in 1897.

Dr. Samuel Phillips, Leavenworth, Kansas, aged 89, died in St. John's Hospital, Leavenworth, October 31. He graduated from the University of Maryland, Baltimore, in 1853. He was at one time a surgeon in the army.

Dr. James Welch, Tampa, Kansas, aged 50, died suddenly at his office, October 16, from heart disease. He was a graduate of the College of Physicians and Surgeons, Kansas City, in 1903. He was a veteran of the Spanish-American War and was commissioned a first lieutenant, M. C. U. S. Army, in the recent war. Was member of the Kansas Medical Society.

Dr. George M. Bower, aged 82, died at his home in Lenexa, recently. He graduated from Bellevue Hospital Medical College in 1862 and practiced medicine until 1906 when he became a banker. He was a state senator in 1872-73.

Dr. Robert I. Fletcher, aged 87, died at the home of his son in Arma, Kansas, September 25, from cerebral hemorrhage. He graduated from the College of Physicians and Surgeons, Keokuk, Iowa, in 1857. He was a surgeon of the U. S. Volunteers during the Civil War.

Dr. Richard W. Lease, Redfield, Kansas, aged 68, died November 9. He graduated from the College of Physicians and Surgeons, Keokuk, Iowa, in 1878. He was a member of the Kansas Medical Society.

—R—

BOOKS

The Surgical Clinics of Chicago

Volume 3, Number 5 (October, 1919). Octavo of 258 pages, 91 illustrations. Philadelphia and London: W. B. Saunders Company, 1919. Published bi-monthly. Price, per year, paper, \$10; cloth, \$14.

The October number of the Surgical Clinics of Chicago meets ones greatest expectations. There are in this number clinics by Eisendrath, Kellogg Speed, Oliver and Culbertson at Cook County Hospital; clinics by A. D. Bevan, Bevan and Gill, Gatewood, McWhorter, Kretschmer, Herbst and Davis at the Presbyterian Hospital; clinics by Major Potts and Major Montgomery at the U. S. A. General Hospital at Fort Sheridan; a clinic by A. J. Ochsner at Augustana Hospital; one by Watkins at St. Luke's Hospital, and one by Cornell at the Chicago Lying-In Hospital.

It is a very interesting collection of

cases, many of them belonging to the unusual class. The procedures are described with definite precision and the illustrations are excellent.

—R—

"Flu" Precautions by Armour & Co.

The medical department of Armour & Company has taken precautions among plant employes against a return of the "flu" epidemic in Chicago and other cities where the Armour plants are located.

All employes have been notified that without charge they may have the influenza vaccine administered according to the formula of Dr. E. C. Rosenow.

In addition to offering this vaccine free to employes, a general educational campaign along health lines and particularly with reference to the "flu" is being carried on among the workers in the plant.

Dr. Volney S. Cheney, medical director of Armour & Company, reports that the employes are taking an interest in the campaign and that as a result no serious recurrence of influenza is looked for among the Armour workers.

—R—

Can Diphtheria Mortality be Reduced?

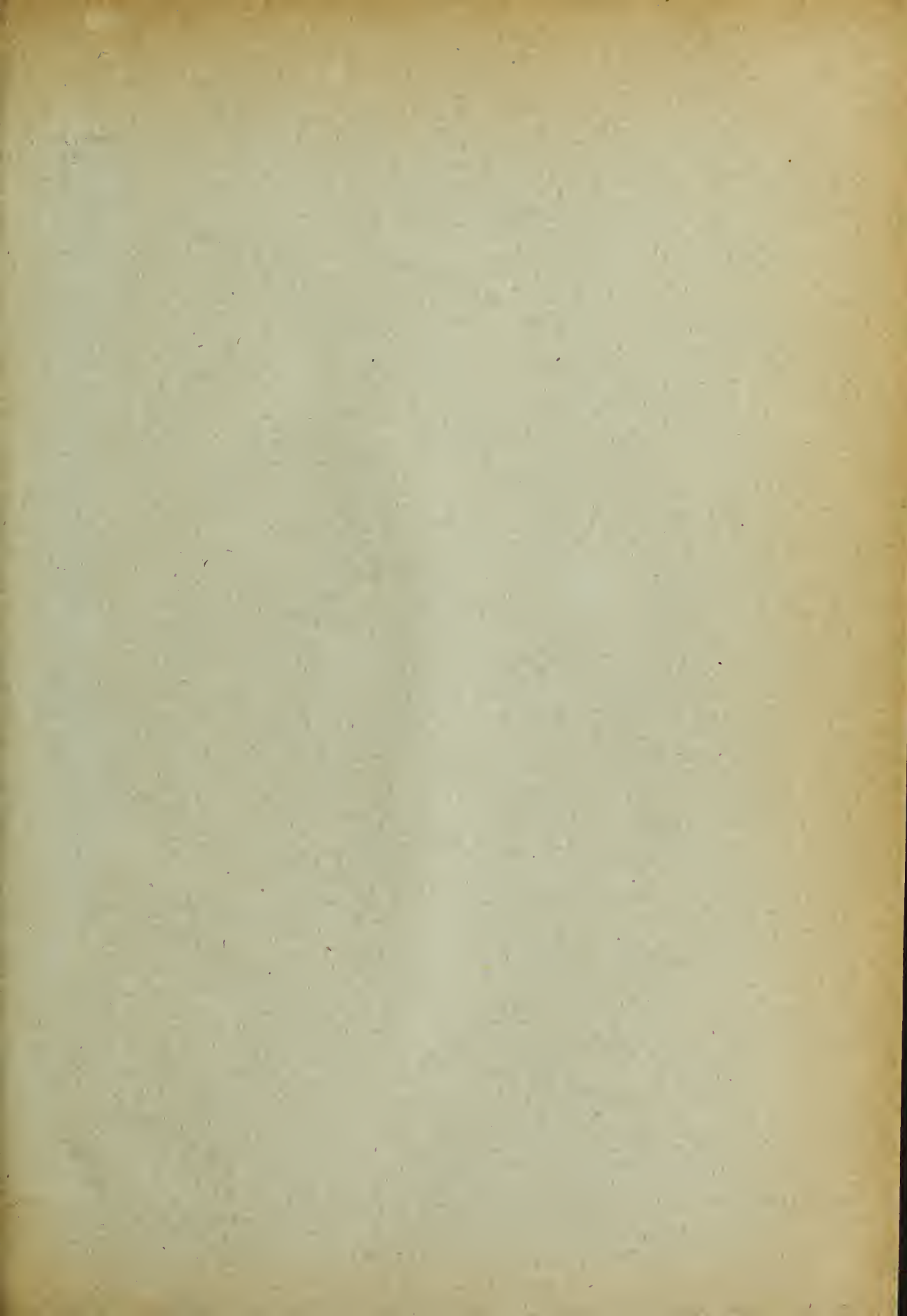
Despite the fact that diphtheria antitoxin is practically a specific, one out of ten cases of diphtheria terminates in death.

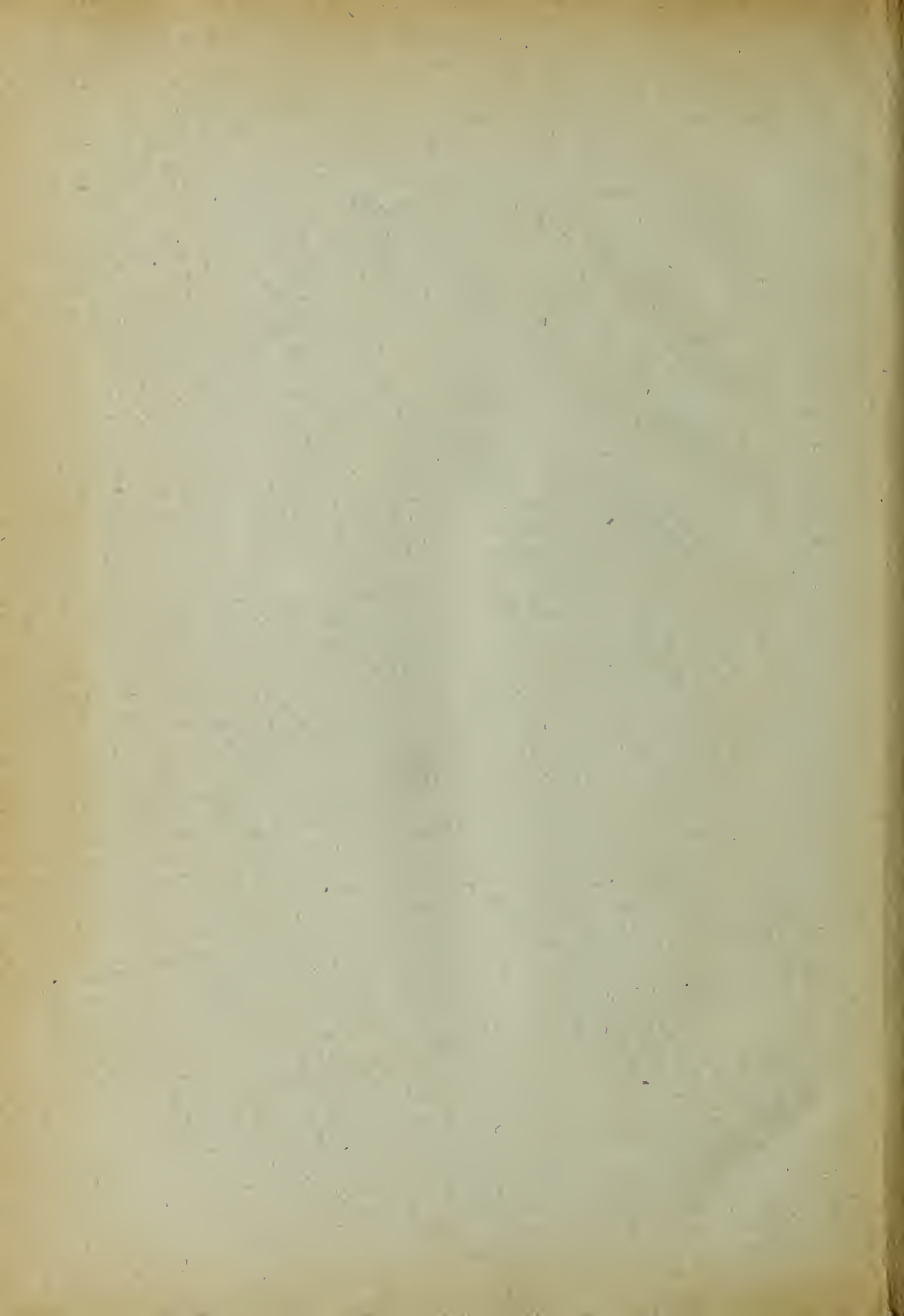
Why this high death rate?

Two reasons: Tardiness in the use of diphtheria antitoxin, and the employment of too small doses. The average dose of diphtheria antitoxin at the present time is 5,000 units. Authorities maintain that it should be 10,000 units.

Physicians who get the best results from diphtheria antitoxin use large doses early in the course of the disease. They administer initial injections of ten to twenty thousand units in all suspected cases. There is little danger from over-dosage of antitoxin. This fact is generally conceded. The real danger lies in the employment of too small doses.

Biological manufacturers are turning out serum of higher potency than formerly. Newer methods of refinement and concentration have resulted in a better product. The antitoxin produced by Parke Davis & Company at the present time is three to five times as concentrated as the antitoxin supplied several years ago. Physicians readily recognize the advantages of Parke Davis & Company's refined and concentrated high-potency diphtheria antitoxin. There is less serum to inject, absorption is more prompt, and the results are quicker and better.





4/A 517

